

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04967

CERTIFICATE OF DEATH

04967

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Carroll Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u>		c. LENGTH OF STAY IN 1b <u>34 yrs.</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Carroll County General Hospital</u>		d. STREET ADDRESS <u>4 Pitt Road</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>CHARLES WILLIAM BANKERT</u>		4. DATE OF DEATH Month Day Year <u>APRIL 7 1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 10, 1910</u>
9. AGE (In years last birthday) <u>56</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Assistant manager of Soft Drink Bottling Co.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Union Mills Carroll Co. Md.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George W. Bankert</u>		14. MOTHER'S MAIDEN NAME <u>Myrtle Matsum</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes WWII</u>		16. SOCIAL SECURITY NO. <u>213-05-1191</u>	
17. INFORMANT <u>Mr. Madeline C. Bankert</u>		Address <u>Same address</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute peritonitis</u> DUE TO (b) <u>reticulum cell carcinoma</u> DUE TO (c) <u>4-5 days</u>			INTERVAL BETWEEN ONSET AND DEATH <u>4-5 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Sept</u> , 19 <u>66</u> , to <u>April 7</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>April 7</u> , 19 <u>67</u> , and that death occurred at <u>7:30 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>John S. Harshey</u>		22b. DATE SIGNED <u>4/7/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOHN S. HARSHEY M.D.</u>		22d. ADDRESS <u>8 Quaker St. Westminster, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>4/10/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Parsons Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Salisbury, Md.</u>
24. FUNERAL DIRECTOR <u>L. E. Myers, Jr. Westminster, Md.</u>		25a. REC'D BY REGISTRAR <u>APR 11 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

02880

1920

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04968

CERTIFICATE OF DEATH

04968

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hampstead	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Carroll Co. General Hospt.		d. STREET ADDRESS 215 1/2 Main Street	
3. NAME OF DECEASED (Type or print) First Ida Middle Helema Last Belt		4. DATE OF DEATH Month 4 Day 1 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 22, 1896
9. AGE (In years last birthday) 70 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Carroll Co. Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Jonas Lippy		14. MOTHER'S MAIDEN NAME Emily Lowe	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 218-32-5104	
17. INFORMANT Mr. Orion E. Belt		Address Carrollton, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE 116X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) RHEUMATIC HEART DISEASE DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH WEEKS YEARS			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) PULMONARY EMPHYSEMA			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 3/25 , 19 67 , to 4/1 , 19 67 , that (I) (we) last saw the deceased alive on 4/1 , 19 67 , and that death occurred at 9:43 P.M. from causes and on the date stated above.			
22a. SIGNATURE <i>Theresa J. Kocak</i>		22b. DATE SIGNED 4/1/67	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF April 5, 1967	23c. NAME OF CEMETERY OR CREMATORY Wesley Cemetery	23d. LOCATION (City or Town) (County) (State) Carroll Co. Md.
24. FUNERAL DIRECTOR Tipton- Eline Funeral Home		25a. REC'D BY REGISTRAR APR 5 1967	
ADDRESS Hampstead, Md.		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1990

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VR A15 (4)
20M 1/65

<div style="display: flex; justify-content: space-between;"> <div> <p>3</p> <p>1</p> </div> <div> <p>04969</p> </div> </div> <div style="text-align: center;"> <p>MARYLAND STATE OF HEALTH</p> <p>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</p> <p>CERTIFICATE OF DEATH</p> <p>04969</p> </div>											
1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Westminster c. LENGTH OF STAY IN 1b 5 Days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Carroll County General Hospital					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Glyndon Upperco d. STREET ADDRESS Hanover Road Upperco e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) Rose			First M.		Middle Bianca		Last Bianca			4. DATE OF DEATH Month April Day 26 Year 19 67	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 19, 1881		9. AGE (In years last birthday) 85 yrs.		IF UNDER 1 YEAR Months 03 Days 2 IF UNDER 24 HRS. Hours 00 Min. 00	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (County & State, or foreign country) Cefalu, Italy			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME John Ranzino						14. MOTHER'S MAIDEN NAME Mary Raimondi					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Jennie M. Bucci Address Hanover Rd. Upperco, Md					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 334X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) Cerebral arteriosclerosis DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Baltimore		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from April 21, 1967 , to April 26, 1967 , that (I) (we) last saw the deceased alive on April 26, 1967 , and that death occurred at 9:05 AM , from the causes and on the date stated above.											
22a. SIGNATURE John S. Harshey						M.O. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 4/26/67			
22c. PHYSICIAN'S NAME (Type) JOHN S. HARSHEY, M.D.						22d. ADDRESS 8 Ancker St. Westminster, Md					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 5/1/67		23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery			23d. LOCATION (City, town or county) (State) Baltimore, Maryland			
24. FUNERAL DIRECTOR Wm. Cook-Brooks Towson 1050 York Rd. 21204						25a. REGISTERED BY REGISTRAR APR 28 1967 25b. REGISTRAR'S SIGNATURE Charles Judge					

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04970

CERTIFICATE OF DEATH

04970

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MIDDLEBURG</u>		c. LENGTH OF STAY IN lb <u>1 YEAR</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>BROOKFIELD MANOR NURSING HOME</u>		d. STREET ADDRESS <u>BARK HILL</u>	
3. NAME OF DECEASED (Type or print) <u>CHARLES FRANCIS BOWERS</u>		4. DATE OF DEATH Month <u>APRIL</u> Day <u>16</u> Year <u>19 67</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT 13 - 1886</u>
9. AGE (In years last birthday) <u>80</u> yrs.		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWNER</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>CHARLES W BOWERS</u>		14. MOTHER'S MAIDEN NAME <u>LAURA L. (UNKNOWN)</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>217-36-3945</u>	
17. INFORMANT <u>CATHERINE V YOUNG</u>		Address <u>YORK PA.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO <u>4221</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerotic C.V.D.</u> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u> <u>years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>9/7/60</u> , 19 <u>60</u> , to <u>4/16/67</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>4/15/67</u> , 19 <u>67</u> , and that death occurred at <u>12:30 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>M.E. Robertson</u>		22b. DATE SIGNED <u>4/17/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>ME ROBERTSON</u>		22d. ADDRESS <u>New Windsor, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>4-19-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>PIPE CREEK</u>	23d. LOCATION (City or Town) (County) (State) <u>CARROLL CO MD</u>
24. FUNERAL DIRECTOR <u>DD Hartzler & Sons</u>		25a. REC'D BY REGISTRAR <u>APR 19 1967</u>	
ADDRESS <u>Union Bridge</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

05020

1992

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

VR A15 (4)
20M 1/65

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
04971 CERTIFICATE OF DEATH 04971										
1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u>				c. LENGTH OF STAY IN 1b <u>40 YRS.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>69 PENNA. AVE.</u>					d. STREET ADDRESS <u>69 PENNA. AVE.</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <u>JOSEPH UPTON BOWERS</u>			4. DATE OF DEATH Month Day Year <u>APRIL 27 1967</u>							
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>NOV 17 1892</u>		9. AGE (In years last birthday) <u>74</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PRESSER, CLOTHING FACTORY</u>			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country) <u>CARROLL Co. MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>JAMES BOWERS</u>					14. MOTHER'S MAIDEN NAME <u>FLORENCE MITTEN</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>			16. SOCIAL SECURITY NO. <u>215-05-6124A</u>		17. INFORMANT <u>MRS. MILDRED L. BOWERS</u>			Address <u>SAME ADDRESS</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>1621</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Alveolar Adeno-Carcinoma both lungs</u> DUE TO (c) <u>about 9 mo</u>								INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arterio-sclerotic Heart Disease</u>								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office/bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Oct. 17</u> , 19 <u>65</u> , to <u>4-27</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>4-26</u> , 19 <u>67</u> , and that death occurred at <u>6:30 P.</u> M, from the causes and on the date stated above.										
22a. SIGNATURE <u>C. W. Billingslea</u>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED <u>4-28-67</u>		
22c. PHYSICIAN'S NAME (Type) <u>C. W. Billingslea</u>					22d. ADDRESS <u>Westminster, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>5/1/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>MEADOW BRANCH CEMETERY</u>			23d. LOCATION (City, town or county) (State) <u>WESTMINSTER MD.</u>			
24. FUNERAL DIRECTOR <u>J. E. Myers, Jr.</u>					ADDRESS <u>WESTMINSTER, MD.</u>		25a. REC'D BY REGISTRAR <u>J. Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	

01010

01010



04972

CERTIFICATE OF DEATH

04972

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 38 years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Pearl Jacobs Callender		4. DATE OF DEATH Month Day Year 4 27 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 03-04-92
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY AT HOME	9. AGE (In years last birthday) 75 yrs.
11. BIRTHPLACE (County & State, or foreign country) Maryland, Baltimore		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Morris Jacobs		14. MOTHER'S MAIDEN NAME Mary	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 220-54-6671	
17. INFORMANT Med. Record		Address Springfield Hospital, Sykesville, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure DUE TO (b) Metastatic carcinoma of the liver due to DUE TO (c) Old breast cancer			INTERVAL BETWEEN ONSET AND DEATH days years years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Schizophrenic Reaction, Paranoid type.			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (X) (this hospital) attended the deceased from 6-25-29 , 19 67 , to 4-27 , 19 67 , that (X) (we) last saw the deceased alive on April 27 , 19 67 , and that death occurred at 11:45 A.M. from causes and on the date stated above.			
22a. SIGNATURE <i>[Signature]</i>		22b. DATE SIGNED 4-27-67	
22c. PHYSICIAN'S NAME (Type) Naci Buyukunsal, M.D.		22d. ADDRESS Springfield Hospital, Sykesville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 4/28/67	23c. NAME OF CEMETERY OR CREMATORY OHEB SHALOM	23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND
24. FUNERAL DIRECTOR SOL LEVINSON & BROS. INC., 6010 REIST., RD.		25a. REC'D BY REGISTRAR MAY 1 1967	
25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04973 Item #7 Film 70301 4/11/67 pc

1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 30 W. Green St.		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Carroll c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster d. STREET ADDRESS 30 W. Green St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ODEN CORTLAND CORBIN		4. DATE OF DEATH April 4 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 2 1888
9. AGE (In years last birthday) 78 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Real Estate	11. BIRTHPLACE (County & State, or foreign country) Carroll Co. Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME William L. Corbin	
14. MOTHER'S MAIDEN NAME Florence Yingling		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO	
16. SOCIAL SECURITY NO. 214-01-0698		17. INFORMANT John E. Corbin, same address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Pancreas 157X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Metastases to liver & lung DUE TO (b) Leukemia DUE TO (c) Leukemia		INTERVAL BETWEEN ONSET AND DEATH 2 yrs. 2 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <input checked="" type="checkbox"/>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year 19	
20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 590	
20f. (City or town) 4-4-67		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 4-3-1967 to 4-4-67 , that (I) (we) last saw the deceased alive on 4-3-1967 and that death occurred at 4-4-67 M, from the causes and on the date stated above.			
22a. SIGNATURE James G. Saffell MD		22b. DATE SIGNED 4-6-67	
22c. PHYSICIAN'S NAME (Type) James G. Saffell		22d. ADDRESS Main St. Reisterstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF April 7 1967	
23c. NAME OF CEMETERY OR CREMATORY Meadow Branch		23d. LOCATION (City, town or county) Carroll Co. Md.	
24. FUNERAL DIRECTOR'S SIGNATURE J. E. Myers, Jr. Westminster, Md.		25a. REC'D BY REGISTRAR APR 10 1967	
25b. REGISTRAR'S SIGNATURE J. Charles Judge		25c. DATE APR 10 1967	

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1981 10 1 1981

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04974

04974

1. PLACE OF DEATH a. COUNTY <u>Carroll Co.</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town). <u>Westminster</u> c. LENGTH OF STAY IN b. <u>84 yrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>50 Liberty St.</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u> d. STREET ADDRESS <u>50 Liberty St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>JENNIE LOUISE DIFFENDAL</u>				4. DATE OF DEATH Month <u>APRIL</u> Day <u>5</u> Year <u>1967</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 18 1882</u>	
9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Carroll Co. - Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Jacob H. Handley</u>				14. MOTHER'S MAIDEN NAME <u>Annie M. Warner</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)				16. SOCIAL SECURITY NO. <u> </u>			
17. INFORMANT <u>Martin W. Diffendal</u>				Address <u>same address</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Artery Disease</u> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>(Had Influenza + Pneumonitis)</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Senility</u> INTERVAL BETWEEN ONSET AND DEATH <u>Some years</u> <u>Some years</u> <u>2 weeks</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a.m. <u> </u> p.m. <u> </u>		Month, Day, Year <u> </u> <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Jan. 24th</u> , 19 <u>67</u> , to <u>Apr. 5th</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>April 4th</u> , 19 <u>67</u> , and that death occurred at <u>8:30</u> A.M. from the causes and on the date stated above.							
22a. SIGNATURE <u>J. E. Billingslea</u> M.D.				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <u>J. E. Billingslea</u>				22d. ADDRESS <u>Westminster, Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4/7/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Frederick Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Westminster, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Myers, Jr.</u>				25a. REC'D BY REGISTRAR <u>APR 7 1967</u>			
ADDRESS <u>Westminster, Md.</u>				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

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James H. Handley

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General 4/17/75 James County Rural, Westminster, N.D.
J. B. Thompson, Westminster, N.D. - 1887

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
04975 CERTIFICATE OF DEATH 04975									
1. PLACE OF DEATH a. COUNTY CARROLL b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) WESTMINSTER RD#4 c. LENGTH OF STAY IN 1b 50 YRS. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) ROUTE 140					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY CARROLL c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) WESTMINSTER, RD#4 d. STREET ADDRESS ROUTE 140 e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) LAURA BURNETTE DRECHSLER			First Middle Last		4. DATE OF DEATH APRIL 20 1967		Month Day Year		
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH FEB. 6, 1886		9. AGE (In years last birthday) 81 yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE-WIFE				10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN G. ELY					14. MOTHER'S MAIDEN NAME BERTHA BOLTE				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) -				16. SOCIAL SECURITY NO. -		17. INFORMANT LESTER E. DRECHSLER Address SAME ADDRESS			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Valvular Heart Disease 4214 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) - DUE TO (c) - DUE TO (b) - DUE TO (c) - PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Influenza with Bronchitis								INTERVAL BETWEEN ONSET AND DEATH 10+ yrs	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>								20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1957 , 19 1957 to April 19 1967 that (I) (we) last saw the deceased alive on Apr. 19 1967 , and that death occurred at 3:30 P.M. from the causes and on the date stated above.									
22a. SIGNATURE Freese Wilkens M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						22b. DATE SIGNED 4/20/67			
22c. PHYSICIAN'S NAME (Type) FREESE WILKENS						22d. ADDRESS Kempers Ave. Westminster Md			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)			
BURIAL		4/22/67		EVERGREEN MEM. GARDENS		FINKSBURG RD MD			
24. FUNERAL DIRECTOR J. E. Impro. Jr., Westminster, Md ADDRESS						25a. REC'D BY REGISTRAR James J. [unclear]		25b. REGISTRAR'S SIGNATURE James J. [unclear]	
						DATE APR 24 1967			

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CARROLL

MARYLAND

CARROLL

WESTMINSTER ROAD 201/2 WESTMINSTER, MD#4

ROUTE 140 ROUTE 140

APRIL 20 1961 LORRA BURNETTE BRECHER

FEB 6 1886 81

FEMALE WHITE

N-20

MARYLAND

HOUSE-WIFE

JOHN G. ELY

BERTHA BOLTE

LESTER E. BRECHER, MARYLAND



BURIAL # 101/2 EVERETT NEW GARDEN FINKBORG ROAD

2-2-1961, Westminister, Md

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

**FOR STATE
HEALTH DEPT.**

04976

04976

1. PLACE OF DEATH a. COUNTY CARROLL		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE MARYLAND b. COUNTY CARROLL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) UNIONTOWN		c. LENGTH OF STAY IN 1b MINUTES	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) _____		d. STREET ADDRESS _____	
3. NAME OF DECEASED (Type or print) STERLING RAY ECKER		4. DATE OF DEATH Month APRIL Day 1 Year 1967	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEB 13-1915
9. AGE (In years last birthday) 52 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TENANT		10b. KIND OF BUSINESS OR INDUSTRY FARMER	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME STERLING ECKER		14. MOTHER'S MAIDEN NAME FLORENCE STRINE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 218-09-6245	
17. INFORMANT ILENE ECKER		Address UNIONTOWN MD	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Crushed Left Chest 9/12/1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, DUE TO (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Sudden	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED, Nature of Injury in Part I of Part II of Item 18 Tractor upset, R. hand wheel came loose on left chest	
20c. TIME OF INJURY Month, Day, Year 11:00 a.m. 4-1 1967		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Farm		20f. (City or town) (County) (State) RD 5 Westminster Md Carroll	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
ACTUAL SIGNATURE W Glenn Speicher EXAMINER'S NAME (Type) W GLENN SPEICHER		22. DATE SIGNED 4-1-67 Address (Street, City, Town, or County) Westminster Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 4/4/67	
23c. NAME OF CEMETERY OR CREMATORY PIPE CREEK		23d. LOCATION (City, town or county) (State) CARROLL CO MD	
24. FUNERAL DIRECTOR DD Hartzler & Sons New Windsor, Md		25a. REC'D BY REGISTRAR APR 4 1967	
25b. REGISTRAR'S SIGNATURE [Signature]			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

03010

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[Faint, mostly illegible text, possibly bleed-through from the reverse side of the page. Some words like "Warrant" and "Return" are faintly visible.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04977
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY CARROLL MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY CARROLL			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WESTMINSTER				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WESTMINSTER, MD.			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) CARROLL CO. GEN. HOSP				d. STREET ADDRESS 154 PENNA AVE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last LEVERE LEWIS ESSOM				4. DATE OF DEATH Month Day Year APR 2 1967			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 14, 1911	
9. AGE (In years last birthday) 56 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WORKER, MEAT PACKING PLANT		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) WESTMINSTER, MD U.S.A.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME CHARLES WM. ESSOM			
14. MOTHER'S MAIDEN NAME FLORENCE LOATS				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WWII			
16. SOCIAL SECURITY NO. 219-01-4512				17. INFORMANT MRS FLORENCE L. ESSOM, ADDRESS SAME			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CORONARY ARTERY DISEASE 1 YEAR (c) ARTERIOSCLEROTIC CARDIOVASCULAR DIS 2 YEAR				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that (I) (this hospital) attended the deceased from SEPT 1965 to APRIL 1967 , that (I) (we) last saw the deceased alive on APRIL 2 1967 , and that death occurred at 5:15 M. from the causes and on the date stated above.			
22a. SIGNATURE Daniel E Welliver				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 4-2-67	
22c. PHYSICIAN'S NAME (Type) DANIEL E WELLIVER				22d. ADDRESS 19 RIDGE RD WESTMINSTER			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/5/67		23c. NAME OF CEMETERY OR CREMATORY KRIDERS CEMETERY		23d. LOCATION (City, town or county) (State) WESTMINSTER MD	
24. FUNERAL DIRECTOR J. E. Myers Jr., Westminster, Md.				25a. REC'D BY REGISTRAR APR 5 1967		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

23 May, Westminster, Md

Grave #1217 KRIDERS CEMETERY WESTMINSTER, MD

DAVID I WELLIVER 19 RIDGE RD WESTMINSTER

APRIL 5 1917

CEAT 31 APRIL 1917

4-5-17

POSTEROSCLOTTIC CHOLESTEROL DISY
CORONARY ARTERY DISEASE 1 YEAR
ACUTE MYOCARDIAL INFARCTION —

YES WHITE 24-41-175 WBS FLORENCE L. ESSOM, ADDRESS

CHARLES WM. ESSOM FLORENCE LONTZ SAME

WORKER, MEAT PACKING PLANT WESTMINSTER, MD 11 24

MALE WHITE

Jan. 14, 1911 26

LEVERE LEWIS ESSOM APR 5 1917

CARROLL CO. E. 1100 124 PENNA AVE

WESTMINSTER D. O. A. WESTMINSTER, MD

CARROLL

MARYLAND

CARROLL

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be placed in the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7-67

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
04978		Item #2d Film #G307 4/10/67 pc						04978			
1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Manchester, Md</u>				c. LENGTH OF STAY in lb <u>16 MON</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Manchester, Md</u>				d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Long View Nursing Home</u>						d. STREET ADDRESS <u>126 N. Main Street</u>					
3. NAME OF DECEASED (Type or print) <u>Philip Jacob Flator</u>						4. DATE OF DEATH Month <u>April</u> Day <u>1</u> Year <u>1967</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>NOV 19, 1873</u>		9. AGE (In years last birthday) <u>93</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter (Postal Clerk)</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Carroll Co</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>			
13. FATHER'S NAME <u>Philip Flator</u>						14. MOTHER'S MAIDEN NAME <u>Elizabeth Whitler</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u> </u>				16. SOCIAL SECURITY NO. <u>212-01-4400</u>		17. INFORMANT <u>Margaret Munson</u> Address <u>Manchester, Md.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u> 11/201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u> </u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>pernicious Anemia -</u> INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs</u>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <u> </u>		(County) <u> </u> (State) <u> </u>	
21. I certify that (1) (this hospital) attended the deceased from <u>Sept 1947</u> to <u>4/1/1967</u> , that (1) (we) last saw the deceased alive on <u>4/1/1967</u> , and that death occurred at <u>6:00 PM</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>W.H. Foard</u>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE <u>4/1/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>W.H. Foard MD</u>						22d. ADDRESS <u>Manchester, Md</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4/4/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Sandymount Cemetery</u>				23d. LOCATION (City, town or county) (State) <u>Sandymount, Carroll Co. Md.</u>			
24 FUNERAL DIRECTOR'S SIGNATURE <u>Tipton - Eline Funeral Home Hampstead, Md.</u>						25a. REC'D BY REGISTRAR DATE <u>APR 5 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Jones</u>			

01352

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04979

CERTIFICATE OF DEATH

04979

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster		c. LENGTH OF STAY IN 1b Month Rural-Woodbine	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Carroll Co. General Hospital		d. STREET ADDRESS R.D. 1	
3. NAME OF DECEASED (Type or print) First ROSE Middle F. Last FLEMING		4. DATE OF DEATH Month 4 Day 13 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 6, 1912
9. AGE (In years last birthday) 54 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Baltimore City, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Swiston		14. MOTHER'S MAIDEN NAME Pauline ?	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 216-03-2766	
17. INFORMANT Mr. Raymond O. Fleming Same As #2		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral vascular accident</u> DUE TO (b) <u>Hypertensive cardiovascular disease</u> DUE TO (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH 17 DAYS YEARS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>3/27</u> , 19 <u>67</u> , to <u>4/13</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>4/13</u> , 19 <u>67</u> , and that death occurred at <u>7:26</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Vincent J. Fiocco</u> M.D.		22b. DATE SIGNED 4/13/67	
22c. PHYSICIAN'S NAME (Type) Vincent J. Fiocco		22d. ADDRESS Westminster, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/16/1967	
23c. NAME OF CEMETERY OR CREMATORY Morgan Chapel		23d. LOCATION (City or Town) (County) (State) Carroll Co., Md.	
24. FUNERAL DIRECTOR C. M. Waltz Box 241 Sykesville, Md.		25a. REC'D BY REGISTRAR APR 17 1967	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

0522

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 is retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04980

CERTIFICATE OF DEATH

04980

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Union Bridge c. LENGTH OF STAY IN 1b years d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) E. Broadway				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Maryland b. COUNTY Carroll c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Union Bridge d. STREET ADDRESS E. Broadway e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Gordon Middle Hunter Last Fogle		4. DATE OF DEATH Month April Day 3 Year 19 67					
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 16, 1886	9. AGE (In years last birthday) 81 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer		10b. KIND OF BUSINESS OR INDUSTRY Cement Plant		11. BIRTHPLACE (County & State, or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME John Wesley Fogle			14. MOTHER'S MAIDEN NAME Mary C. Flickinger				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) no no		16. SOCIAL SECURITY NO. 213-03-1095		17. INFORMANT Address A. Pauline Fogle, Union Bridge, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Atherosclerosis 4500 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH years.		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Hiatus Hernia, with hemorrhage							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour e.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 9/23/64 19 to 4/3/67 19 , that (I) (we) last saw the deceased alive on 4/1/67 19 , and that death occurred at 12 NOON PM , from the causes and on the date stated above.							
22a. SIGNATURE J. H. Caricofe		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 4/3/67			
22c. PHYSICIAN'S NAME (Type) J. H. Caricofe M.D.		22d. ADDRESS Union Bridge, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 4/6/1967	23c. NAME OF CEMETERY OR CREMATORY Lutheran Cemetery		23d. LOCATION (City, town or county) (State) Uniontown, Maryland			
24. FUNERAL DIRECTOR'S SIGNATURE D. Hartzler & Sons		ADDRESS Union Bridge, Md.		25a. REC'D BY REGISTRAR APR 5 1967 DATE 25b. REGISTRAR'S SIGNATURE Charles Judge			

08220

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Carroll

Carroll

Carroll

Union Bridge

Union Bridge

Years

E. Broadway

E. Broadway

Gordon

Forfe

Winter

White

Jan. 10, 1888

Engineer

General Agent

Virginia

U.S.A.

John Wesley Forfe

John C. Forfe

no

1888-03-10 A. Forfe, Union Bridge, Va.

General Agent

J. H. Carls

Union Bridge, Virginia

Union Bridge, Va.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
3500 4-64

MAYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
04981											
1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u> c. LENGTH OF STAY IN ID <u>DOA</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>DOA CARROLL CO GENERAL HOSPITAL</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>UNION BRIDGE</u> d. STREET ADDRESS <u>205 MAIN ST</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>RICHARD LEROY FORNEY</u> First Middle Last 4. DATE OF DEATH <u>APRIL - 14 - 1967</u> Month Day Year						5. SEX <u>M</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>DEC 16 - 1941</u> 9. AGE (In years last birthday) <u>25</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MACHINE OPERATOR</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>CONSTRUCTION</u> 11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>						13. FATHER'S NAME <u>CLAUDE E FORNEY</u> 14. MOTHER'S MAIDEN NAME <u>EDITH REESE</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service)						16. SOCIAL SECURITY NO. <u>218-38-3891</u> 17. INFIRMANT <u>CELINE FORNEY</u> Address <u>MD</u> <u>UNION BRIDGE</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fractured Cervical Vertebra</u> <u>824.0</u> DUE TO (b) <u>Skull injury + multiple Body</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>Lacerations</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
MEDICAL CERTIFICATION 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <u>Fell out of truck rounding curve on Hawk Hill Road</u> 20c. TIME OF INJURY Month, Day, Year <u>10:30 PM 4-14-67</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Hawk Hill Rd Union Bridge Carroll Md</u> 20f. (City or town) (County) (State)											
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> EXAMINER'S NAME (Type) <u>W GLENN SPEICHER</u> M.D. Address (Street, city, town or county) <u>135 E. Westminister Carroll</u> 22. DATE SIGNED <u>4-14-67</u>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				23b. DATE THEREOF <u>4-17-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>WINTERS</u>		23d. LOCATION (City, town or county) <u>NEW WINDSOR MD</u>			
24. FUNERAL DIRECTOR <u>DW Hartzler & Sons Union Bridge, Md</u> ADDRESS								25a. REC'D BY REGISTRAR <u>APR 18 1967</u> DATE		25b. REGISTRAR'S SIGNATURE <u>J Charles Judge</u>	

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APR 1 1961
K. J. [illegible]

04982

CERTIFICATE OF DEATH

04982

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Westminster</u>			c. LENGTH OF STAY IN 1b <u>31 Years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Westminster</u> <u>06-1</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>R.D. 6</u>				d. STREET ADDRESS <u>R. D. 6</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>AMOS</u> Middle <u>R.</u> Last <u>GARTRELL</u>				4. DATE OF DEATH Month <u>April</u> Day <u>25</u> Year <u>19 67</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 18, 1889</u>		9. AGE (In years last birthday) <u>77</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired-B.&O. R.R.</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Carroll Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Aaron Gartrell</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth ?</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>705-12-3665</u>		17. INFORMANT Address <u>Mrs. Orlando Farver R.D. Mt. Airy, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <u>177x</u> IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO (b) <u>Prostatic hypertrophy, Carcinoma</u> DUE TO (c) <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.						INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>6 mos</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Coronary occlusion</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>7/1</u> , 19 <u>65</u> , to <u>4/25</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>4/25</u> , 19 <u>67</u> , and that death occurred at <u>1058</u> P. M. from causes and on the date stated above.							
22a. SIGNATURE <u>Julius Chapko</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>4/26/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. Julius Chapko</u>				22d. ADDRESS <u>851 W. Green St. Westminster, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4/28/1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Morgan Chapel</u>		23d. LOCATION (City or Town) (County) (State) <u>Carroll Co., Md.</u>	
24. FUNERAL DIRECTOR <u>C. M. Waltz Bo x 241 Sykesville, Md.</u>				25a. REC'D BY REGISTRAR <u>APR 28 1967</u>		25b. REGISTRAR'S SIGNATURE <u>J Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove and retain the funeral papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

06933

CERTIFICATE OF DEATH

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1964-1965

1966-1967

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained in the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

04983

04983

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SYKESVILLE</u>				c. LENGTH OF STAY IN 1b <u>3 MO.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PULLEN NURSING HOME</u>				d. STREET ADDRESS <u>COR. MAIN AND BOND STS.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>E.</u> Last <u>Haines</u>				4. DATE OF DEATH Month <u>7</u> Day <u>11</u> Year <u>1967</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>SEPT. 18 1877</u>	
9. AGE (In years last birthday) <u>89</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) <u>CARROLL CO. MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>CARROLL CO. MD.</u>	
13. FATHER'S NAME <u>JOHN BARNES</u>				14. MOTHER'S MAIDEN NAME <u>MARTHA HOOK</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service) <u>—</u>				16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT Address <u>E. GREEN ST. MRS. S. HERBERT YINGLING WESTMINSTER</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> DUE TO <u>4321</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic heart failure</u> <u>5 yrs.</u> DUE TO <u>Arteriosclerotic C.V. disease</u> <u>10 yrs.</u> (c) <u>—</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19 <u>—</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>1.12</u> 19 <u>67</u> , to <u>4.11</u> 19 <u>67</u> , that I last saw the deceased alive on <u>4.3</u> 19 <u>67</u> , and that death occurred at <u>7:45 P.</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Sykesville, MD</u> DATE SIGNED <u>4.11.67</u> ACTUAL SIGNATURE <u>Sani Okutman</u> M.D. <u>Sykesville, MD</u> PHYSICIAN'S NAME (Type) <u>Sani Okutman</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/14/67</u>		22c. NAME OF CEMETERY OR CREMATORY <u>MT. PLEASANT CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>FINKSBURG RD #2 MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. S. Myers, Jr.</u> ADDRESS <u>Westminster, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>APR 17 1967</u>		24b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

10

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04984

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04984

1. PLACE OF DEATH a. COUNTY CARROLL MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Pennsylvania b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WESTMINSTER				c. LENGTH OF STAY IN 1b Shippensburg			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) CARROLL COUNTY GENERAL HOSPITAL				d. STREET ADDRESS 36 West King Street			
3. NAME OF DECEASED (Type or print) First Middle Last WAYNE Franklin HAMMOND				4. DATE OF DEATH Month Day Year 4 25 1967			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 26, 1907	
9. AGE (In years lost birthday) yrs. 59		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Osteopath		11. BIRTHPLACE (State or foreign country) Spring Run, Pa.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Martin Franklin Hammond				14. MOTHER'S MAIDEN NAME Mary Ann Wolff			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address Mrs. Emma Hammond same address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Werner U. Spitz M.D.				22. DATE SIGNED 4-25-67			
EXAMINER'S NAME (Type) WERNER U. SPITZ, M.D.				DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF 4/29/1967		23c. NAME OF CEMETERY OR CREMATORY Spring Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Shippensburg, Pa.	
24. FUNERAL DIRECTOR Wm. J. T. ...				25a. REC'D BY REGISTRAR APR 27 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

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30 West King Street

30 West King Street

May 2, 1977

For the City of

For the City of

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
04985 CERTIFICATE OF DEATH 04985											
1. PLACE OF DEATH a. COUNTY Carroll MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Finksburg #2						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Finksburg #2					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Kay's Mill Road						d. STREET ADDRESS Kay's Mill Road					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First EVA Middle MAY Last HANSEN						4. DATE OF DEATH Month APRIL Day 11 Year 1967					
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH AUG 21 1891		9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months 7 Days 11 Hours 19 Min. 67	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife				10b. KIND OF BUSINESS OR INDUSTRY housewife				11. BIRTHPLACE (County & State, or foreign country) Baltimore		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Harasha Nelson Justice						14. MOTHER'S MAIDEN NAME Carrie E. Hardysheil					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no						16. SOCIAL SECURITY NO. 214-170-7724		17. INFORMANT Howard F. Hansen Address Brodbeck RD #1 Puma			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION 4301 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE DUE TO (c) 3 MOS INTERVAL BETWEEN ONSET AND DEATH 2-3 MIN											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.						20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from SEPT 1966 to JAN 11 1967 , that (I) (we) last saw the deceased alive on JAN 11 1967 , and that death occurred at 6 PM , from the causes and on the date stated above.											
22a. SIGNATURE William J. Stewart						M.D. ATTENDING PHYS. <input type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) William J. Stewart						22d. ADDRESS J. E. Myers, Jr., Westminster, Md.		22b. DATE SIGNED 4/11/67			
23a. BURIAL, CREMATION, REMOVAL (Specify) burial				23b. DATE THEREOF April 14/67		23c. NAME OF CEMETERY OR CREMATORY Sandymount Cemetery				23d. LOCATION (City, town or county) (State) Finksburg #1 Maryland	
24. FUNERAL DIRECTOR J. E. Myers, Jr., Westminster, Md.						25a. REC'D BY REGISTRAR APR 13 1967		25b. REGISTRAR'S SIGNATURE J. Charles Judge			

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04986

CERTIFICATE OF DEATH

04986

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Westminster</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Sykesville</u>	
c. LENGTH OF STAY IN 1b <u>2 weeks</u>		d. STREET ADDRESS <u>Mineral Hill Road</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Carroll Co. Gen. Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>John Clarence Harpine</u>		4. DATE OF DEATH Month Day Year <u>April 3, 1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-24-1906</u>
9. AGE (In years last birthday) <u>67</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mechanic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Auto</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>VA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Lemuel Harpine</u>		14. MOTHER'S MAIDEN NAME <u>Cynthia Golliday</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>Mrs. Golda Harpine</u>		Address <u>Sykesville, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>5810</u> DUE TO <u>Carbonyl of the liver</u> (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			19. INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Chronic bronchitis</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Nat While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Mar 17, 1967</u> , to <u>April 3, 1967</u> , that (I) (we) last saw the deceased alive on <u>April 3, 1967</u> , and that death occurred at <u>9:15</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>John S. Harshey</u>		22b. DATE SIGNED <u>4/2/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOHN S. HARSHEY, M.D.</u>		22d. ADDRESS <u>8 Melrose St. Westminster, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>4-5-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Lake View Memorial Park</u>	23d. LOCATION (City or Town) (County) (State) <u>Sykesville Md.</u>
24. FUNERAL DIRECTOR <u>Larry W. Knight</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
ADDRESS <u>Sykesville, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
3500 4-64

<div style="display: flex; justify-content: space-between;"> <div> <p>1</p> <p>04987</p> </div> <div> <p>MARYLAND STATE DEPARTMENT OF HEALTH</p> <p>Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</p> <p>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</p> </div> <div> <p>04987</p> </div> </div>											
1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MANCHESTER RD #1</u>				c. LENGTH OF STAY IN 1b <u>1 WEEK</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER RD #5</u>				d. STREET ADDRESS <u>RD #5</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)						d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>WILLIAM LESTER HIGGINS</u>						4. DATE OF DEATH Month Day Year <u>4 - 23 1967</u>					
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JUNE 2 1906</u>		9. AGE (In years last birthday) <u>60</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TIMBER AND LOGGING EMPLOYEE</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>BURNSVILLE, N.C.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>MOULT HIGGINS</u>						14. MOTHER'S MAIDEN NAME <u>ANNIE RANDOLPH</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>410-34-0366</u>		17. INFORMANT Address <u>MRS. MAUDE S. HIGGINS, RD #5, MD.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis (auto)</u> 4201 DUE TO Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>W. Glenn Speicher</u>						M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) <u>W. Glenn Speicher</u>						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
						Address (Street, city, town, or county) <u>135 E. Main St. Westminister, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				23b. DATE THEREOF <u>4/26/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>MANCHESTER BAPTIST</u>			23d. LOCATION (City, town or county) (State) <u>MANCHESTER RD #1 MD</u>		
24. FUNERAL DIRECTOR <u>S. S. Myers, Jr. Westminister, Md.</u>						25a. REC'D BY REGISTRAR DATE <u>APR 26 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

04984

MEDICAL EXAMINER - CERTIFICATE OF DEATH

01807

FOR STATE HEALTH DEPT.

WILLIAM F. ZACK

1. Name of deceased: WILLIAM F. ZACK
2. Sex: M
3. Age: 70
4. Date of death: 10-10-1964
5. Place of death: 1000 1/2 N. 1st St., St. Paul, Minn.
6. Cause of death: Myocardial infarction
7. Manner of death: Natural
8. Signature of medical examiner: [Signature]
9. Title of medical examiner: Medical Examiner
10. Date of certification: 10-10-1964

11. Name of physician: [Signature]
12. Title of physician: Physician
13. Date of certification: 10-10-1964
14. Name of coroner: [Signature]
15. Title of coroner: Coroner
16. Date of certification: 10-10-1964
17. Name of registrar: [Signature]
18. Title of registrar: Registrar
19. Date of certification: 10-10-1964
20. Name of clerk: [Signature]
21. Title of clerk: Clerk
22. Date of certification: 10-10-1964

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

04988

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04988

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>		c. LENGTH OF STAY IN ID <u>1 YEAR</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u> 06-1			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Pullen Nursing Home</u>				d. STREET ADDRESS <u>MAIN St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Myrtle</u> Middle <u>Virginia</u> Last <u>Hipsley</u>		4. DATE OF DEATH Month <u>April</u> Day <u>22</u> Year <u>1967</u>					
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-4-1891</u>	9. AGE (in years last birthday) <u>76</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Condon</u>				14. MOTHER'S MAIDEN NAME <u>Josephine Long</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>Mr. Willie Hipsley - Sykesville, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized Ca of Breast</u> <u>170X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Ca. of Breast</u> DUE TO (c) <u>"</u>						INTERVAL BETWEEN ONSET AND DEATH <u>7 yrs</u> <u>7 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus; Arteriosclerotic Cardiovascular</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Aug 10</u> , 19 <u>67</u> , to <u>APR 22</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>APR 21</u> , 19 <u>67</u> , and that death occurred at <u>10P</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Sani Okutman</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>4-25-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Sani Okutman</u>				22d. ADDRESS <u>Sykesville, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4-27-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Springfield Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Sykesville, Md.</u>	
24. FUNERAL DIRECTOR <u>Harry W. Haight Sykesville, Md.</u>				25a. REC'D BY REGISTRAR DATE <u>MAY 1 1967</u>			
				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
CERTIFICATE OF DEATH													
04989 Item #8 Film #V307-4/12/67 DE						04989							
1. PLACE OF DEATH a. COUNTY <u>Howard Carroll</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Carroll</u>							
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Springfield Ave - Sykesville, Md.</u>							
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Springfield Ave.</u>						d. STREET ADDRESS <u>Springfield Ave</u>							
3. NAME OF DECEASED (Type or print) First <u>NATHAN</u> Middle <u>C.</u> Last <u>Hobbs, Jr.</u>						4. DATE OF DEATH Month <u>April</u> Day <u>3</u> Year <u>1967</u>							
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1922</u> <u>12-5-1923/1</u>		9. AGE (In years last birthday) <u>44</u> yrs.		IF UNOER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Md.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
13. FATHER'S NAME <u>Nathan Hobbs, Sr.</u>						14. MOTHER'S MAIDEN NAME <u>Gertrude Shipley</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>?</u>		17. INFORMANT Address <u>Mrs. Gertrude Hobbs, Sykesville, Md.</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Influenza</u> <u>4201</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>Myocarditis</u> DUE TO (c) <u>Coronary thrombosis and Cardiac Arrest.</u>												INTERVAL BETWEEN ONSET AND DEATH <u>4/1/67</u> <u>through</u> <u>4/3/67</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <u>April 1, 1967</u> , to <u>April 3, 1967</u> , that (I) (we) last saw the deceased alive on <u>April 3, 1967</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.													
22a. SIGNATURE <u>Howard E. Hall</u>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>April 3, 1967</u>					
22c. PHYSICIAN'S NAME (Type) <u>Howard E. Hall, M.D.</u>						22d. ADDRESS <u>Sykesville, Maryland</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4-6-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Springfield Cemetery</u>				23d. LOCATION (City, town or county) (State) <u>Sykesville, Md.</u>					
24. FUNERAL DIRECTOR <u>Harry W. Knight</u>						25a. REC'D BY REGISTRAR <u>APR 10 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					

0203

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7-62

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
04930		Item #2a,b,c & d Form #G387 1/10/67 pc						04930			
1. PLACE OF DEATH a. COUNTY <u>Carroll</u>				b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Manchester</u>				c. LENGTH OF STAY IN 1b <u>153</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Truven Nursing Home</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				f. STREET ADDRESS <u>Carlisle St.</u>			
3. NAME OF DECEASED (Type & print) <u>Jennie M. Hostetter</u>				4. DATE OF DEATH <u>4</u> <u>2</u> <u>1967</u>				5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <u>October 19-1889</u>				9. AGE (In years last birthday) <u>77</u> yrs.				10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			
11. BIRTHPLACE (County & State, or foreign country) <u>Allenstown Pa</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Charles E. Hostetter</u>			
14. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				15. SOCIAL SECURITY NO. <u>176-05-2009</u>				16. INFORMANT <u>G.H. Hostetter</u>			
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Myocarditis</u> DUE TO <u>Arteriosclerotic Cardio Vascular Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Arteriosclerotic Cardio Vascular Disease</u> DUE TO <u>Arteriosclerotic Cardio Vascular Disease</u> DUE TO <u>Arteriosclerotic Cardio Vascular Disease</u>				18. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>							
20c. TIME OF INJURY Month, Day, Year <u>19</u>				20d. INJURY OCCURRED <u>White</u> <input type="checkbox"/> <u>Not White</u> <input type="checkbox"/> <u>at work</u> <input type="checkbox"/> <u>at work</u> <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>			
20f. (City or town) <u>Manchester</u>				20g. (County) <u>Carroll</u>				20h. (State) <u>Maryland</u>			
21. I certify that (I) (this hospital) attended the deceased from <u>Oct. 20</u> , 19 <u>67</u> , to <u>April 2</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>April 2</u> , 19 <u>67</u> , and that death occurred at <u>9:35</u> AM, from the causes and on the date stated above.											
22a. SIGNATURE <u>Joseph E. Bush</u>				22b. DATE SIGNED <u>April 2</u>				22c. PHYSICIAN'S NAME (Type) <u>Joseph E. Bush MD</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>4/5/67</u>				23c. NAME OF CEMETERY OR CREMATORY <u>St. Ann's</u>			
23d. LOCATION (City, town or county) <u>Manchester Pa</u>				23e. (State) <u>Pa</u>				23f. (Country) <u>U.S.A.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Wayne V. Keworthy</u>				24a. ADDRESS <u>269 Fredrick St. Hanover</u>				24b. DATE <u>APR 4 1967</u>			
25a. REGISTRAR'S SIGNATURE <u>James J. Jones</u>				25b. REGISTRAR'S SIGNATURE <u>James J. Jones</u>				25c. REGISTRAR'S SIGNATURE <u>James J. Jones</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04991

Item #7 Film #G388 4/25/67 pc

CERTIFICATE OF DEATH

04991

1. PLACE OF DEATH a. COUNTY <u>CARROLL COUNTY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL CO.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MANCHESTER</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>CARROLL COUNTY GENERAL HOSPITAL</u>		e. STREET ADDRESS <u>RT #1</u>	
3. NAME OF DECEASED (Type or print) <u>HAROLD EUGENE JENNINGS</u>		4. DATE OF DEATH <u>APRIL 17 1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>FEB. 21, 1925</u>
9. AGE (In years last birthday) <u>42</u> yrs.		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>GENERAL LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>VARIOUS</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>SCOTT COUNTY VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>CREED I. JENNINGS</u>		14. MOTHER'S MAIDEN NAME <u>MAMIE BOATRIGHT</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>YES. WWII</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>ROBERT P. JENNINGS</u> Address <u>BROTHER CATE CITY VA. RT #2</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Aspirated gastric ulcer</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>24h</u> <u>36h</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>aspirated pneumonia</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>April 16</u> , 1967, to <u>April 17</u> , 1967, that (I) (we) last saw the deceased alive on <u>April 17</u> , 1967, and that death occurred at <u>9:15</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Robert F. Bell, M.D.</u>		22b. DATE SIGNED <u>April 17, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>ROBERT F. BELL MD</u>		22d. ADDRESS <u>187 E. MAIN WESTMINSTER, MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>4/20/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>JESSEE CEMETERY</u>		23d. LOCATION (City or Town) (County) (State) <u>NICKELSVILLE SCOTT CO. VA.</u>	
24. FUNERAL DIRECTOR <u>James G. Saffell</u> ADDRESS <u>WESTMINSTER, MD</u>		25a. REC'D BY REGISTRAR <u>APR 19 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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CERTIFICATE OF DEATH

Reg. Dist. No.

04992

04992

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>UNION BRIDGE</u>		c. LENGTH OF STAY IN 1b <u>YEARS</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>UNION BRIDGE</u>		d. STREET ADDRESS <u>RURAL</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>RURAL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>MOSES EUGENE JONES</u>		4. DATE OF DEATH Month Day Year <u>APRIL 11 1967</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>COLORED</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT 25-1918</u>
9. AGE (In years last birthday) <u>48</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS, OR INDUSTRY <u>BODY WORKS</u>	11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>DIRRONDER G. JONES</u>	
14. MOTHER'S MAIDEN NAME <u>ANNA MATTHEWS</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>	
16. SOCIAL SECURITY NO. <u>231-18-9666</u>		17. INFORMANT Address <u>Mrs. MARY K. JONES UNION BRIDGE MD</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO <u>11/201</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardiac Failure - Chronic</u> DUE TO <u>years</u> (c) <u>years</u>		INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>years</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>12/1/56</u> , 19 <u>56</u> , to <u>4/11/67</u> , 19 <u>67</u> , that I last saw the deceased alive on <u>3/10/67</u> , 19 <u>67</u> , and that death occurred at <u>10:50 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>M. E. Robertson</u>		DATE SIGNED <u>4/11/67</u>	
PHYSICIAN'S NAME (Type) <u>M. E. ROBERTSON M.D. NEW WINDSOR MD</u>		ADDRESS (Street, city or town, state)	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>4-14-67</u>	22c. NAME OF CEMETERY OR CREMATORY <u>ST. JAMES CEM. NEW WINDSOR MD.</u>	22d. LOCATION (City, town, or county) (State) <u>MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>D. H. Hartshorn</u>		24a. REC'D BY REGISTRAR <u>APR 14 1967</u>	
ADDRESS <u>UNION BRIDGE MD</u>		24b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, page 3 should be attached far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
04993					04993						
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)						
a. COUNTY <i>Carroll</i>					a. STATE <i>Md.</i>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Manchester Md.</i>					b. COUNTY <i>Balto.</i>						
c. LENGTH OF STAY IN 1b <i>11 month</i>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Upperco</i>						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Imperial Nursing Home 128 N Main St</i>					d. STREET ADDRESS <i>none.</i>						
e. IS RESIDENCE IN A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
3. NAME OF DECEASED (Type or print)			First <i>Lillie</i>			Middle <i>May</i>			Last <i>Kemp.</i>		
4. DATE OF DEATH			Month <i>4</i>			Day <i>26</i>			Year <i>1967</i>		
5. SEX <i>Female</i>		6. COLOR OR RACE <i>white</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>3-5-1877</i>		9. AGE (In years last birthday) <i>90</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>—</i>				11. BIRTHPLACE (County & State, or foreign country) <i>Balto County on farm.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Oliver Cox</i>						14. MOTHER'S MAIDEN NAME <i>Susan Wilhelm</i>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>				16. SOCIAL SECURITY NO. <i>217-48-0292</i>		17. INFORMANT <i>Leslie Kempson</i>				Address <i>615 Maryland Ave Baltimore Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute myocardial infarction</i> 4221 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <i>Arterio-sclerosis & Diabetes</i> DUE TO (c) <i>General Arterio Sclerosis</i>										INTERVAL BETWEEN ONSET AND DEATH <i>24 hrs.</i> <i>20 yrs.</i> <i>25 yrs.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (1) (this hospital) attended the deceased from <i>July</i> , 19 <i>67</i> , to <i>4-26-67</i> , 19 <i>67</i> , that (2) (we) last saw the deceased alive on <i>4-26</i> , 19 <i>67</i> , and that death occurred at <i>9:30</i> AM, from the causes and on the date stated above.											
22a. SIGNATURE <i>M.C. Porterfield</i>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>4-26-67</i>			
22c. PHYSICIAN'S NAME (Type) <i>M.C. Porterfield</i>						22d. ADDRESS <i>Hampstead, Md.</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>			23b. DATE THEREOF <i>4/29/67</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Forest Baptist Cemetery</i>			23d. LOCATION (City, town or county) (State) <i>Upperco, Md.</i>			
24. FUNERAL DIRECTOR <i>Tipton - Eline Funeral Home Hampstead, Md.</i>						ADDRESS <i>—</i>		25a. REC'D BY REGISTRAR <i>Charles Judge</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

04333

STATE OF TEXAS

1900

Witnessed by
Notary Public

213-40-000

100

NOTARY PUBLIC

MADE IN U.S.A.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04994

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04994

1. PLACE OF DEATH o. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 1 day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital				d. STREET ADDRESS 911 N. Carrollton Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last JAMES EDWARD KING				4. DATE OF DEATH Month Day Year April 25 19 67			
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-9-16		9. AGE (In years last birthday) yrs. 50	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Rug Cleaner		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Mary (Maiden name unknown)			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 248-24-8221		17. INFORMANT Address Records, Springfield State Hospital			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute fatty change of the liver. 5810 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE William Specker		EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, City, Town, or County)		22. DATE SIGNED 47 25-67	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 5/5/67		23c. NAME OF CEMETERY OR CREMATORY Mt. Calvary Cemetery		23d. LOCATION (City or Town) (County) (State) A A County Md	
24. FUNERAL DIRECTOR ADOLPHUS HALSTEAD Address 1206 W. North Ave				25a. REC'D BY REGISTRAR MAY 4 1967		25b. REGISTRAR'S SIGNATURE John A. Judge	

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04995

CERTIFICATE OF DEATH

04995

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH o. COUNTY Carroll		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland		b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Sykesville		c. LENGTH OF STAY IN lb. 1y. 6d.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		01-2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital				d. STREET ADDRESS 548 N. Center St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Clomenzie First Clarley Middle Lambert Last		4. DATE OF DEATH April 28 19 67		8. DATE OF BIRTH Feb 25 1889		9. AGE (In years last birthday) 78 yrs.	
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY --		11. BIRTHPLACE (County & State, or foreign country) Maryland West Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Benjamin Shuttlesworth				14. MOTHER'S MAIDEN NAME Missouri * Ashby			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Springfield Hospital records, Sykesville, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure DUE TO (b) Terminal broncho pneumonia DUE TO (c) Days						INTERVAL BETWEEN ONSET AND DEATH Days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) associated with senile brain disease with psychotic reaction						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (this hospital) attended the deceased from 4/22 , 19 66 , to 4/28 , 19 67 that (we) last saw the deceased alive on 4/28 19 67 , and that death occurred at 10 PM, from causes and on the date stated above.							
22a. SIGNATURE Naci D. Buyukunsal				22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) Naci Buyukunsal, M.D.	
22d. ADDRESS Springfield State Hospital Sykesville, Maryland		22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 2, 1967		23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		23d. LOCATION (City or Town) (County) (State) Near Cumberland Alleg Md	
24. FUNERAL DIRECTOR John J. Hoyer				25a. REC'D BY REGISTRAR DATE MAY 23 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

52210

1950

Letter

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH																			
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND																			
MEDICAL EXAMINER'S CERTIFICATE OF DEATH																			
1. PLACE OF DEATH a. COUNTY <u>CARROLL CO</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>														
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER RD.</u>					c. LENGTH OF STAY IN 1b <u>?</u>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>UNION BRIDGE RD #1</u>									
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>DEEP RUN ROAD OFF ROUTE 140</u>					d. STREET ADDRESS					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) <u>ROBERT DAVID LEESE</u>					4. DATE OF DEATH Month <u>APRIL</u> Day <u>22</u> Year <u>1967</u>														
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JULY 25 1939</u>		9. AGE (In years last birthday) <u>27</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>EMPLOYEE IN GREENHOUSE (FLORIST)</u>					10b. KIND OF BUSINESS OR INDUSTRY					11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>					12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				
13. FATHER'S NAME <u>CLAYTON J. LEESE</u>					14. MOTHER'S MAIDEN NAME <u>HELEN WEIDNER</u>														
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>					16. SOCIAL SECURITY NO. <u>214-36-9641</u>					17. INFORMANT Name <u>DANIEL W. LEESE</u> Address <u>UNION BRIDGE RD #1</u> <u>MARYLAND</u>									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gunshot Left chest</u> <u>976X</u> DUE TO (b) <u>25 caliber S&W</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>Interval between onset and death</u>										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>apparently shot himself in left chest</u> <u>25 Cal. Pistol</u>														
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>4</u> p.m. <u>1967</u>					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory (street or address, etc.) <u>Union Bridge Rd 3 Westminister Md</u>					20f. City or town (County) (State) <u>Carroll Md</u>				
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>																			
ACTUAL SIGNATURE <u>W. L. Spencer</u>										22. DATE SIGNED <u>4-22-67</u>									
EXAMINER'S NAME (Type) <u>W. L. Spencer</u>										22. DATE SIGNED <u>4-22-67</u>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>					23b. DATE THEREOF <u>4/25/67</u>					23c. NAME OF CEMETERY OR CREMATORY <u>ST DAVIDS CEMETERY</u>					23d. LOCATION (City, town or county) (State) <u>NR. HANOVER PA. ADAMS Co. PA.</u>				
24. FUNERAL DIRECTOR <u>J. E. Thompson, Jr. Westminster, Md.</u>										25a. REC'D BY REGISTRAR <u>APR 26 1967</u>					25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04997

CERTIFICATE OF DEATH

04997

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Carroll			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Millers			c. LENGTH OF STAY IN 1b 46 years			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Millers	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) R.D.1				d. STREET ADDRESS R.D. 1			e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) Ida R. Lucabaugh				4. DATE OF DEATH Month April Day 15 Year 1967			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 7, 1878		9. AGE (In years last birthday) yrs. 88	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (County & State, or foreign country) Harford Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Hudson				14. MOTHER'S MAIDEN NAME Annia C. Peregory			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 213-38-8397		17. INFORMANT Address Mrs. Corinne Tracey Millers, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Certain Schism Cr. Disease DUE TO (b) Dementia Melli'tus DUE TO (c) 							INTERVAL BETWEEN ONSET AND DEATH 1860. 25 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (1) (this hospital) attended the deceased from Jan. , 19 60 , to 4-15 , 19 67 , that (1) (we) last saw the deceased alive on 4-12 , 19 67 , and that death occurred at 12:50 AM , from causes on and on the date stated above.							
22a. SIGNATURE Maurice C. Porterfield				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 4-17-67	
22c. PHYSICIAN'S NAME (Type) Maurice C. Porterfield				22d. ADDRESS Hampstead, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/18/67		23c. NAME OF CEMETERY OR CREMATORY Steltz Union Cem.		23d. LOCATION (City or Town) (County) (State) New Freedom Pa.	
24. FUNERAL DIRECTOR Tipton - Eline Funeral Home Hampstead, Md.				25a. REC'D BY REGISTRAR DATE Apr 18 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

MEDICAL CERTIFICATION

7029

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04998

CERTIFICATE OF DEATH

04998

1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster c. LENGTH OF STAY IN 1b 50 YRS. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 143 E. Green Street		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster d. STREET ADDRESS 143 E. Green St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MAUD Middle ESTELLE Last MANAHAN		4. DATE OF DEATH Month April Day 10 Year 1967	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 27, 1888
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) nurse		10b. KIND OF BUSINESS OR INDUSTRY County Health Dept Carroll County	11. BIRTHPLACE (County & State, or foreign country) U.S.A.
13. FATHER'S NAME Charles F. Manahan		14. MOTHER'S MAIDEN NAME Ada Nicodemus	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) --		16. SOCIAL SECURITY NO. 219-36-1867	17. INFORMANT Miss Martha E. Manahan Address same
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF COLON WITH METASTASES 1538 DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH 8 MONTHS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from AUG. 8, 1966 , to APRIL 10, 1967 , that (I) (we) last saw the deceased alive on APRIL 9, 1967 , and that death occurred at 12:30 PM , from the causes and on the date stated above.			
22a. SIGNATURE William J. Stewart,		M.D. <input checked="" type="checkbox"/> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 4/10/67
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF April 12/67	23c. NAME OF CEMETERY OR CREMATORY Westminster Cemetery	23d. LOCATION (City, town or county) (State) Westminster, Maryland
24. FUNERAL DIRECTOR J. E. Myers Jr., Westminster, Md.		25a. REC'D BY REGISTRAR APR 13 1967	25b. REGISTRAR'S SIGNATURE J. Charles Judge

3220

520 J. F. RISA

04999

CERTIFICATE OF DEATH

04999

1. PLACE OF DEATH a. COUNTY Carroll County MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Esquesville, Md.		c. LENGTH OF STAY IN 1b 10 mos.	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown, Maryland		d. STREET ADDRESS 1 E. Baltimore St.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Eva Mae Jones May		4. DATE OF DEATH Month Day Year April 20 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-31-85 87
9. AGE (In years last birthday) 79 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook		10b. KIND OF BUSINESS OR INDUSTRY School	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Layman Jones		14. MOTHER'S MAIDEN NAME Rachel Smith	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 219-20-4359	
17. INFORMANT Med Rec		Address Sykesville, Springfield St. Hospital, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure DUE TO (b) Arteriosclerotic cardiovascular disease DUE TO (c) Terminal pneumonia			INTERVAL BETWEEN ONSET AND DEATH years weeks
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Chronic Brain Syndrome, associated with senile brain disease with psychotic reaction			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) psychotic reaction	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 6-15 , 19 66 , to 4-19 , 19 67 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 4-19 , 19 67 , and that death occurred at 3:50 PM , from causes and on the date stated above.			
22a. SIGNATURE R. Espina, M.D.		22b. DATE SIGNED 4-19-67	
22c. PHYSICIAN'S NAME (Type) R. Espina, M.D.		22d. ADDRESS Springfield State Hospital	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 4/24/67	23c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEMETERY	23d. LOCATION (City or Town) (County) (State) HAGERSTOWN WASH. CO. MD.
24. FUNERAL DIRECTOR Reiger Funeral Home		25a. REC'D BY REGISTRAR APR 27 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05000

CERTIFICATE OF DEATH

05000

1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville c. LENGTH OF STAY IN lb 7yrs. 10mos. 21dys. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 304 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last SARAH EDITH MAYS		4. DATE OF DEATH Month Day Year APRIL MARCH/ 12 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-10-1882
9. AGE (In years lost birthday) 84 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Factory Worker		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Bennett Hoshall		14. MOTHER'S MAIDEN NAME Elizabeth Gore	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 218-09-9789	
17. INFORMANT Records, Springfield State Hospital		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) Coronary arteriosclerosis DUE TO (c) Arteriosclerotic cardiovascular disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Psychotic depressive reaction.			
INTERVAL BETWEEN ONSET AND DEATH Hours Years Years			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 5-21-59 , 19__ to 4-12-67 , 19__, that (I) (we) last saw the deceased alive on 4-12-67 , 19__, and that death occurred at 11:50 PM from causes and on the date stated above.			
22a. SIGNATURE Agustin del Campo 22c. PHYSICIAN'S NAME (Type) Agustin del Campo, M. D.		22b. DATE SIGNED 4-12-67 22d. ADDRESS Springfield State Hospital Sykesville, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/15/67	
23c. NAME OF CEMETERY OR CREMATORY Middletown Baptist Cem.		23d. LOCATION (City or Town) (County) (State) Middletown, Md.	
24. FUNERAL DIRECTOR Tipton- Eline Funeral Home		25a. REC'D BY REGISTRAR APR 14 1967 25b. REGISTRAR'S SIGNATURE Charles Judge	

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CERTIFICATE OF DEATH

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CERTIFICATE OF DEATH

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1. PLACE OF DEATH o. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN lb 1 mo. 13 das.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		d. STREET ADDRESS 3905 Edgewood Rd. Apt. 131	
3. NAME OF DECEASED (Type or print) First Harry Middle NMN Last MEYERS		4. DATE OF DEATH Month April Day 16 Year 19 67	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. AGE (In years last birthday) 63 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Real Estate		10b. KIND OF BUSINESS OR INDUSTRY Bondsman	11. BIRTHPLACE (County & State, or foreign country) Maryland
13. FATHER'S NAME Meyer Meyers - dec.		14. MOTHER'S MAIDEN NAME Sara Meyer ? - dec.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 219-32-2028	
		17. INFORMANT Springfield State Hospital Records	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardio-vascular disease. DUE TO (b) Generalized arteriosclerosis. DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. _____			INTERVAL BETWEEN ONSET AND DEATH years years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes Mellites. CBS, circulatory disorder, with psychotic reaction.			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 3-3-67 , 19____, to 4-16-67 , 19____, that (I) (we) last saw the deceased alive on 4-16-67 , 19____, and that death occurred at 11 a.m. from causes and on the date stated above.			
22a. SIGNATURE Octavio Ruiz		22b. DATE SIGNED 4-16-67	
22c. PHYSICIAN'S NAME (Type) Octavio Ruiz, M.D.		22d. ADDRESS Springfield State Hospital, Sykesville, Maryland 21784	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 4/18/67	23c. NAME OF CEMETERY OR CREMATORY New Har Sinai	23d. LOCATION (City or Town) (County) (State) Garrison Maryland
24. FUNERAL DIRECTOR Lol. Levinson		25a. REC'D BY REGISTRAR Charles Judge	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Sykesville c. LENGTH OF STAY IN 1b 13y. 7m. 26d. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City d. STREET ADDRESS 918 E. Chase St. e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Anna Belle Montgomery				4. DATE OF DEATH Month Day Year April 29 1967			
5. SEX Female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 13, 1891	
9. AGE (In years last birthday) 75 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mother's helper		10b. KIND OF BUSINESS OR INDUSTRY **		11. BIRTHPLACE (County & State, or foreign country) unknown	
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME Heroy Montgomery			
14. MOTHER'S MAIDEN NAME unknown				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no - -			
16. SOCIAL SECURITY NO. 220-54-6601				17. INFORMANT Springfield Hospital records, Sykesville, Md			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary failure DUE TO (b) Secondary anemia due to malabsorption yrs. DUE TO (c) associated with disturbance of metabolism, growth or nutrition with senile brain disease, with psychotic reaction PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CBS 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Sept. 23, 1953 , to Apr. 29, 1967 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Apr. 29, 1967 , and that death occurred at 9 A.M. from causes and on the date stated above.							
22a. SIGNATURE Dr. Naci Buyukunsal				22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) Naci Buyukunsal, M.D.	
22d. ADDRESS Springfield State Hospital Sykesville, Md.				23a. BURIAL, CREMATION, REMOVAL (Specify) 5/3/67			
23b. DATE THEREOF				23c. NAME OF CEMETERY OR CREMATORY Johns Hopkins School of Med. 709 N. Wolfe St.			
23d. LOCATION (City or Town) (County) (State) Springfield State Hospital Sykesville, Md.				24. FUNERAL DIRECTOR Newell Funeral Home Pikesville - Md.			
25a. REC'D BY REGISTRAR MAY 4 1967				25b. REGISTRAR'S SIGNATURE Charles Judge			

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SECTION 10 OF DEATH

WILLIAM J. BROWN
JANUARY 15, 1900
WILLIAM J. BROWN

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
05003					05003				
1. PLACE OF DEATH a. COUNTY Carroll					2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Sykesville					b. COUNTY Carroll				
c. LENGTH OF STAY IN 1b 6 Years					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Sykesville				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) R.D. 2 Box 232					d. STREET ADDRESS R. D. 2 Box 232				
3. NAME OF DECEASED (Type or print) First Middle Last Muriel C. Morrison					4. DATE OF DEATH Month Day Year April 19, 1967				
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 5, 1913		9. AGE (In years last birthday) 54 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Inn owner & operator		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Baltimore Co., Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Frank C. Crooks					14. MOTHER'S MAIDEN NAME Mary V. Dorsey				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes give war or dates of service) 216-05-8849		17. INFORMANT Mr. Guy W. Morrison		Address Same As #2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of cervix with extended metastasis 171X DUE TO Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) Post radiation, intestinal obstruction DUE TO (c) Cardiac failure and cardiac arrest.									INTERVAL BETWEEN ONSET AND DEATH 12/66 through 4/19/67
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Dec. 1966, to 4/19/67, 1967, that (I) (we) last saw the deceased alive on April 19, 1967 and that death occurred at 4:35, from the causes and on the date stated above.									
22a. SIGNATURE Howard E. Hall					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED April 20, 1967		
22c. PHYSICIAN'S NAME (Type) Howard E. Hall, M.D.					22d. ADDRESS Sykesville, Maryland				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/22/1967		23c. NAME OF CEMETERY OR CREMATORY Lakeview Memorial Gardens		23d. LOCATION (City, town or county) Carroll Co., Md.			
24. FUNERAL DIRECTOR C. M. Waltz Box 241 Sykesville, Md.					25a. REC'D BY REGISTRAR DATE APR 24 1967		25b. REGISTRAR'S SIGNATURE Charles J. Jones		

MEDICAL CERTIFICATION

00003

00004

05004

CERTIFICATE OF DEATH

05004

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster				c. LENGTH OF STAY IN 1b part of 1 day Westminster			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Carroll County General Hospital				d. STREET ADDRESS N. Center St.			
3. NAME OF DECEASED (Type or print) First RUFUS Middle WILLIAM Last NORWOOD				4. DATE OF DEATH Month April Day 10 Year 1967			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 23, 1880		9. AGE (In years last birthday) 86 yrs.	10. IF UNDER 1 YEAR Months 06 Days 1	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) carpenter		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Ridgeville, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William T. Norwood				14. MOTHER'S MAIDEN NAME Lucy Sellman			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 212-24-6051A		17. INFORMANT Earl E. Norwood Address 6 Norva Avenue Frederick, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 332X DUE TO Cerebral Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Thrombosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Arteriosclerotic heart disease congestive heart failure							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from April 10, 1967 , to April 10, 1967 , that (I) (we) last saw the deceased alive on April 10, 1967 , and that death occurred at 1:15 P.M. , from causes and on the date stated above.							
22a. SIGNATURE John S. Harshey				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 4/10/67	
22c. PHYSICIAN'S NAME (Type) JOHN S. HARSHEY, M.D.				22d. ADDRESS 8 Anchor St Westminster, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF April 13/67		23c. NAME OF CEMETERY OR CREMATORY Pine Grove Cemetery		23d. LOCATION (City or Town) (County) (State) Mt. Airy, Maryland	
24. FUNERAL DIRECTOR J. S. Myers Jr., Westminster, Md.				25a. REC'D BY REGISTRAR APR 13 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

05005

CERTIFICATE OF DEATH

05005

1. PLACE OF DEATH a. COUNTY Carroll, Maryland MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (Rural) Sykesville				c. LENGTH OF STAY IN 1b 10y. 7m. 26d			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital				d. STREET ADDRESS 229 E. 32nd. Street			
3. NAME OF DECEASED (Type or print) First Charles Middle William Last O'Neill				4. DATE OF DEATH Month 4 Day 10 Year 19 67			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-23-90	9. AGE (In years Last birthday) yrs. 76	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ship Pilot		11. BIRTHPLACE (County & State, or foreign country) Maryland
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ship Pilot				10b. KIND OF BUSINESS OR INDUSTRY Bay Pilot on ships		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John R. O'Neill				14. MOTHER'S MAIDEN NAME Margaret Lastner			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no				16. SOCIAL SECURITY NO. 218-32-3886		17. INFORMANT Hospital Records	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Emphysema DUE TO (b) Chronic Bronchitis DUE TO (c) Generalized arteriosclerosis							INTERVAL BETWEEN ONSET AND DEATH 3 yrs. years years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic brain syndrome associated with psychotic reaction, generalized arteriosclerosis							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) --				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) --			
20c. TIME OF INJURY Month, Day, Year Hour a.m. --- p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) --		20f. (City or town) (County) (State) --	
21. I certify that he (this hospital) attended the deceased from 8-14 , 1967 , to 4-10 , 1967 , that he (we) last saw the deceased alive on 4-10 , 1967 , and that death occurred at 11:50 a.m. from causes and on the date stated above.							
22a. SIGNATURE Mario E. Comas M.D.				22b. DATE SIGNED 4-10-67		22c. PHYSICIAN'S NAME (Type) Mario E. Comas, M.D.	
22d. ADDRESS Springfield State Hospital				22e. ADDRESS Sykesville, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Apr. 13, 1967		23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR Wm. Cook-Brooks Towson, 1050 York Road				25a. REC'D BY REGISTRAR APR 12 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1990

02605

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05006

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05006

1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Sykesville c. LENGTH OF STAY IN 1b 4yrs.2mos. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Springfield State Hospital				2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 579 Laurens St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last HATTIE SYLVIA PARKER				4. DATE OF DEATH Month Day Year APRIL 20 19 67			
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-7-1889	
9. AGE (In years last birthday) 78		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME John Myers		14. MOTHER'S MAIDEN NAME Bertha Wilson		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	
16. SOCIAL SECURITY NO. Unk.		17. INFORMANT Records, Springfield State Hospital		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 4221 Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CBS assoc. with cerebral arteriosclerosis, with psychotic reaction				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE W. Glenn Speicher		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22. DATE SIGNED 4-20-67	
EXAMINER'S NAME (Type) W. Glenn Speicher, M. D.		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial					
23b. DATE THEREOF 4/26/1967		23c. NAME OF CEMETERY OR CREMATORY Berkley Cemetery		23d. LOCATION (City, town or county) Charlottesville, Maryland		25a. REC'D BY REGISTRAR Elmer E Bulluck	
24. FUNERAL DIRECTOR Elmer E Bulluck		ADDRESS 556 ... Street		25b. REGISTRAR'S SIGNATURE Charles Judge		DATE APR 27 1967	

2005C

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 05007

05007

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Carroll		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Finksburg		c. LENGTH OF STAY IN lb 7 yrs	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) New Windsor		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Williams Nursing Home			d. STREET ADDRESS 461		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Rebecca Middle May Last Parks			4. DATE OF DEATH Month April Day 11 Year 19 67		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 5, 1877		9. AGE (In years last birthday) 90 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Butler, Md.	
13. FATHER'S NAME John G. Gill			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
14. MOTHER'S MAIDEN NAME Mary Hyde			17. INFORMANT Address Md. Mrs. Eliz. Warehime- 103 Butler Rd., Reisterstown,		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. 215-54-0020		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardio Vascular Disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 7 yrs.					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) none			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. none 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from 1-27-69 , 19____, to 4-11-67 , 19____, that I last saw the deceased alive on April 10 , 19 67 , and that death occurred at 2:15P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 6 Hanover Rd. DATE SIGNED 4-12-67 ACTUAL SIGNATURE D. D. Caples M.D. PHYSICIAN'S NAME (Type) D. D. Caples, M. D. Reisterstown, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-14-67		22c. NAME OF CEMETERY OR CREMATORY Jessop	
22d. LOCATION (City, town, or county) Cockeysville, Balto., Md.		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE D. D. Hartwig & Son			ADDRESS New Windsor, Md.		24a. REC'D BY REGISTRAR DATE APR 14 1967
24b. REGISTRAR'S SIGNATURE Charles Judge					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (1-62)
15M 7-62

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
05008						05008					
1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Manchester</u> c. LENGTH OF STAY IN 1b <u>7 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Longview Nursing Home Inc.</u>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hampstead</u> d. STREET ADDRESS <u>117 Carroll St</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Harry</u>		First <u>Harry</u> Middle <u>Pletzer</u> Last <u>Pletzer</u>		4. DATE OF DEATH Month <u>4</u> Day <u>17</u> Year <u>1967</u>							
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7/23/ '82</u>		9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Lock Installer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>		11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME <u>William L. Pletzer</u>				14. MOTHER'S MAIDEN NAME <u>Laura Kelly</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give year or dates of service)				16. SOCIAL SECURITY NO. <u>243-05-5358</u>		17. INFORMANT <u>Mrs. Arthur C. Bowman</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arterio-sclerosis C.V. Disease</u> DUE TO <u>4321</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u> </u> (c) <u> </u>										INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Pulmonary Emphysema; Chn Bronchitis</u>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from <u>3-28-67</u> to <u>4-17-67</u> , that (I) (we) last saw the deceased alive on <u>4-17-67</u> , and that death occurred at <u>7:10 PM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>M. C. Porterfield</u> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>4-17-67</u>			
22c. PHYSICIAN'S NAME (Type)						22d. ADDRESS <u>Hampstead Md</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4/20/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Evergreen Memorial Gardens</u>		23d. LOCATION (City, town or county) <u>Finksburg Carroll Co. Md.</u>					
24 FUNERAL DIRECTOR'S SIGNATURE <u>Tipton - Eline Funeral Home</u>						ADDRESS <u>Hampstead, Md.</u>		25a. REC'D BY REGISTRAR <u>APR 20 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

05008

STATE OF TEXAS

05008

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05008

STATE OF TEXAS

05009

CERTIFICATE OF DEATH

05009

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Carroll County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>		c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> 3014
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Springfield State Hosp.</u>		d. STREET ADDRESS <u>2304 Madison Ave.</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Georgiana Tankard Revelle</u>		4. DATE OF DEATH Month Day Year <u>4-23-67</u> 19	
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-20-82</u> 85 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <u>85</u> yrs.
11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Emanuel Tankard</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT <u>Springfield Hosp. records</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>Years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>3-28</u> , 19 <u>67</u> , to <u>4-23</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>4-23</u> 19 <u>67</u> , and that death occurred at <u>11:30 A.M.</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Orlando C. Ramos</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>ORLANDO C. RAMOS</u>		22d. ADDRESS <u>Springfield State Hospital</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>4-26-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Ebenezer Cem.</u>	23d. LOCATION (City or Town) (County) (State) <u>Exmore Baltimore, Va.</u>
24. FUNERAL DIRECTOR <u>Edgar K. Wharton</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
ADDRESS <u>new church Va.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
DATE <u>APR 26 1967</u>			

05003

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CERTIFICATE OF DATA

STATE OF NEW YORK
A STATEMENT OF THE RESULTS OF THE
ANALYSIS OF THE SAMPLES OF
WATER TAKEN AT THE
STATION OF THE
NEW YORK STATE DEPARTMENT OF
HEALTH

REPORT OF THE
NEW YORK STATE DEPARTMENT OF
HEALTH
ON THE
ANALYSIS OF THE
SAMPLES OF
WATER TAKEN AT THE
STATION OF THE
NEW YORK STATE DEPARTMENT OF
HEALTH

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

05010

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05010

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Taneytown			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Carroll County General Hospital				d. STREET ADDRESS Route # 1M		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First EARL Middle David Last Roop				4. DATE OF DEATH Month 4 - Day 9 Year 1967			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9/18/1903	
				9. AGE (in years last birthday) 63 yrs.		10. IF UNDER 1 YEAR Months 4 Days 9	
						11. IF UNDER 24 HRS. Hours 4 Min. 10	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer				10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) Carroll Co., Maryland	
						12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George W. Roop				14. MOTHER'S MAIDEN NAME Berta Nogle			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO. 219-36-1146		17. INFORMANT Mrs. Mary Agnes Roop, R# 1M, Taneytown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis (acute) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary disease DUE TO (c) 4 yrs							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE W. Glenn Speicher				22. DATE SIGNED 4-9-67			
EXAMINER'S NAME (Type) W. Glenn Speicher				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, City, Town, or County) 135 E. Main St. Westminster Carroll Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/12/1967		23c. NAME OF CEMETERY OR CREMATORY Keysville Union Cemetery		23d. LOCATION (City, town or county) (State) Keysville, Maryland	
24. FUNERAL DIRECTOR C.O. Fuss & Son, Taneytown, Md.				25a. REC'D BY REGISTRAR APR 11 1967		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND												
05011						05011						
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)						
e. COUNTY			CARROLL			a. STATE			b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			MIDDLEBURG			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			UNION BRIDGE RURAL			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)						d. STREET ADDRESS						
BROOKFIELD MANOR NURSING HOME						BARK HILL						
3. NAME OF DECEASED (Type or print)						4. DATE OF DEATH						
First Middle Last						Month Day Year						
MARY JANE ROWE						APRIL 29 1967						
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		B. DATE OF BIRTH		9. AGE (In years last birthday)		IF UNDER 1 YEAR		
F		W		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		FEB 27-1880		87 yrs.		Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country)				
OPERATOR				NURSING HOME				MARYLAND				
13. FATHER'S NAME						14. MOTHER'S MAIDEN NAME						
ISAAC WELTY						CATHERINE FOX						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO.				17. INFORMANT Address				
NO				218-32-4121				MRS HARRY CARR UNION BRIDGE MD				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)										Years		
443X DUE TO												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										(b)		
										DUE TO (c)		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)										19. WAS AUTOPSY PERFORMED?		
Hypertensive cardiovascular disease										YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCOUNT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY		Month, Day, Year		20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)		
Hour e.m. p.m.		19		While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>								
21. I certify that (I) (this hospital) attended the deceased from 1/17/67 to 4/29/67, 1967, that (I) (we) last saw the deceased alive on 4/29/67, 1967, and that death occurred at 1:30 PM, from the causes and on the date stated above.												
22a. SIGNATURE						ATTENDING PHYS.			MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
JH CARICOFE						M.D.			4/29/67			
22c. PHYSICIAN'S NAME (Type)						22d. ADDRESS						
JH CARICOFE						UNION BRIDGE MD						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City, town or county) (State)				
BURIAL		MAY 2-1967		CHURCH OF GOD				UNION TOWN MD				
24. FUNERAL DIRECTOR'S SIGNATURE						ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
D.D. Hartzler & Sons Union Bridge MD								MAY 2 1967		J Charles Judge		

05011

05012

CELESTIAL DEATH

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CELESTIAL DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled-in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05012

CERTIFICATE OF DEATH

05012

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u> c. LENGTH OF STAY* IN 1b <u>6 mo's. 39 days</u> d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Finksburg, Route #2</u>	
3. NAME OF DECEASED (Type or print) <u>Jarrett Wesley Shauck</u>		4. DATE OF DEATH <u>April 30 1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-20-91</u>
9. AGE (In years last birthday) <u>75</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Butcher</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Shauck</u>		14. MOTHER'S MAIDEN NAME <u>Eliza Barber</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-32-2664-A</u>	
17. INFORMANT <u>Records, Springfield State Hospital</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>493X</u> IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>10/11/66</u> , 19____, to <u>4/30/67</u> , 19____, that (I) (we) last saw the deceased alive on <u>4/30 1967</u> , and that death occurred at <u>9:45 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>H.E. Connor Jr. MD</u>		22b. DATE SIGNED <u>4/30/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>H.E. Connor Jr. MD</u>		22d. ADDRESS <u>Springfield State Hospital Sykesville, Maryland 21784</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>5/3/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Pleasant Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Damascus, Carroll Co. Md.</u>
24. FUNERAL DIRECTOR <u>J. Z. Myers Jr., Westminster, Md 21157</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u> DATE <u>MAY 3 1967</u>	

05018

01020

Estimated State & Federal Income

MAY 3 1961

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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VR A15ME
350D 4-64

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05013

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05013

1. PLACE OF DEATH a. COUNTY CARROLL b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WESTMINSTER c. LENGTH OF STAY IN 1b 20 YRS. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 49 PENNA. AVE.				2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE MARYLAND b. COUNTY CARROLL c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WESTMINSTER d. STREET ADDRESS 49 PENNA. AVE. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																							
3. NAME OF DECEASED (Type or print) MAZIE PAULINE SHIPLEY		4. DATE OF DEATH APRIL 12 1967		5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JUNE 8, 1890		9. AGE (In years last birthday) 76 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Hours Min.											
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE & DOMESTIC WORKER				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) BALTIMORE, MD.				12. CITIZEN OF WHAT COUNTRY? U.S.A.															
13. FATHER'S NAME WILLIAM SUMMERS				14. MOTHER'S MAIDEN NAME MAMMIE PAULINE ?				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) —				16. SOCIAL SECURITY NO. 213-28-1742				17. INFORMANT RALPH G. SHIPLEY, TRAVELTOWN, MARYLAND											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis (acute) 1201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)																INTERVAL BETWEEN ONSET AND DEATH Sudden											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)																											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.												20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)															
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																											
ACTUAL SIGNATURE W. Lewis Spencer				EXAMINER'S NAME (Type) W. Lewis Spencer				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>											
22. DATE SIGNED 4-12-67				Address (Street, City, Town, or County) Westminster, Md.																							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				23b. DATE THEREOF 4/15/67				23c. NAME OF CEMETERY OR CREMATORY KRIDERS CEMETERY				23d. LOCATION (City, town or county) WESTMINSTER, MD.															
24. FUNERAL DIRECTOR J. S. Myers Jr., Westminster, Md.				ADDRESS				25a. REC'D BY REGISTRAR APR 17 1967				25b. REGISTRAR'S SIGNATURE J. Charles Jones															



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WESTERN

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44 PENNA. AVE.

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MARIE PAULINE SHIPLEY

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JUNE 3 1990

FEMALE WHITE

HOUSE WIFE & DOMESTIC WORKER

BALTIMORE MD 4211

WILLIAM ZAMMAG2

ALPHABETIC PAULINE

212-381745-5451-25-212

WAGY 3100
Q. A. 11/1/10

2-3 copies of instructions, etc. 4/11/62 KRIDERS CEMENT WESTMINSTER, MD

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
05014 CERTIFICATE OF DEATH 05014											
1. PLACE OF DEATH a. COUNTY CARROLL b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WESTMINSTER c. LENGTH OF STAY IN 1b 42 YEARS d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 51 UNION STREET						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY CARROLL c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WESTMINSTER d. STREET ADDRESS 51 UNION STREET e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First WALTER Middle THOMAS Last SIMS						4. DATE OF DEATH Month APRIL Day 25 Year 1967					
5. SEX MALE		6. COLOR OR RACE COLORED		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MAR 26 1879		9. AGE (In years last birthday) 88 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MAINTENANCE				10b. KIND OF BUSINESS OR INDUSTRY GRADUATE SCHOOL		11. BIRTHPLACE (County & State, or foreign country) CARROLL, MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME JAMES SIMS						14. MOTHER'S MAIDEN NAME ADMONIA HENRIETTA BENNETT					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO						16. SOCIAL SECURITY NO. 215-32-7718		17. INFORMANT WALTER ATLEE SIMS Address ROUTE #1 NEW WINDSOR, MD			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE 4214 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) PULMONARY FIBROSIS (c) PULVULAR HEART DISEASE INTERVAL BETWEEN ONSET AND DEATH 10 MONTHS 15 YEARS											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from APRIL, 1966 to APRIL, 1967 , that (I) (we) last saw the deceased alive on APRIL 25, 1967 , and that death occurred at 6:58 A.M. from the causes and on the date stated above.											
22a. SIGNATURE Daniel I Welliver						22b. DATE SIGNED 4-25-67					
22c. PHYSICIAN'S NAME (Type) DANIEL I WELLIVER						22d. ADDRESS BRIDGE RD WESTMINSTER MD					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 4/28/67		23c. NAME OF CEMETERY OR CREMATORY Edgewood Cemetery		23d. LOCATION (City, town or county) (State) Westminster Md.				
24. FUNERAL DIRECTOR J. S. Myers, Jr Westminster, Md						25a. REC'D BY REGISTRAR Charles Judge		25b. REGISTRAR'S SIGNATURE Charles Judge			
DATE APR 27 1967											

APR 21 1957

DANIEL J. WELLS
RIDER RD WESTMINSTER
APR 25 57
11-22-57

VALVULAR HEART DISEASE 15 YEARS
PULMONARY FIBROSIS 10 YEARS
CONGESTIVE HEART FAILURE 7 MONTHS

NO
215-32-118 ROUTE 1 NEW WINDSOR, MD
JAMES 21 MS
ADAMIA HENRIETTA BENNETT
MAINTENANCE
GRADUATE SCHOOL CARROLL, MD. U.S.A.
MALE COLORED
WALTER THOMAS 21 MS
APRIL 22 57

21 UNION STREET
WESTMINSTER 112 YEARS WESTMINSTER
CARROLL

05014

05015

CERTIFICATE OF DEATH

05015

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY —			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville			c. LENGTH OF STAY IN 1b 1 yr, 5mo, 25das.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital				d. STREET ADDRESS 3508 Ellamont Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last MINNIE M. ST. PAUL SMITH				4. DATE OF DEATH Month Day Year April 25 1967			
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-28-72		9. AGE (In years last birthday) 94 yrs.		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) domestic		10b. KIND OF BUSINESS OR INDUSTRY Private Family		11. BIRTHPLACE (County & State, or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Uriah St. Paul				14. MOTHER'S MAIDEN NAME Katie E. Smith			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO.		17. INFORMANT Address Lincoln Dowd 3508 Ellamont Rd. Balt. Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ADVANCED Generalized Arteriosclerotic Heart Disease DUE TO (b) Years DUE TO (c) 4200 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic brain syndrome assoc. w/cerebral arteriosclerosis w/psychotic							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) reaction.					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 11-1-65 , 19__ to 4-25-67 , 19__, that (I) (we) last saw the deceased alive on 4-25-67 , 19__, and that death occurred at 2:15 PM , from causes and on the date stated above.							
22a. SIGNATURE Orlando C. Ramos				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 4-25-67	
22c. PHYSICIAN'S NAME (Type) Orlando C. Ramos				22d. ADDRESS Springfield State Hospital			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/1/67		23c. NAME OF CEMETERY OR CREMATORY Poughkeepsie Rural Cem.		23d. LOCATION (City or Town) (County) (State) Poughkeepsie, N.Y.	
24. FUNERAL DIRECTOR ADDRESS Herbert E. Nutter 3035 W. North Ave. Balt. Md				25a. REC'D BY REGISTRAR DATE APR 26 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

05015

05015

EXHIBIT OF 1941

EXHIBIT OF 1941

EXHIBIT OF 1941

EXHIBIT OF 1941

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EXHIBIT OF 1941

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
05016 CERTIFICATE OF DEATH 05016									
1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Carroll</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>			c. LENGTH OF STAY IN 1b <u>YEARS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Marriottsville Road</u>					d. STREET ADDRESS <u>Marriottsville Rd.</u>			e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Alma</u> Middle <u>Inez</u> Last <u>Stanton</u>			4. DATE OF DEATH Month <u>April</u> Day <u>23</u> Year <u>1967</u>						
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Col.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-20-1916</u>		9. AGE (In years last birthday) <u>50</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Houseworker</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Md.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Myers</u>					14. MOTHER'S MAIDEN NAME <u>Etta Thornton</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>?</u>		17. INFORMANT <u>Address</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> <u>4200</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardiac failure,</u> DUE TO (c) <u>Arteriosclerotic heart disease, Hypertension</u>								INTERVAL BETWEEN ONSET AND DEATH <u>4/17/67 through 4/23/67</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>April 17, 1967</u> , to <u>April 23, 1967</u> , that (I) (we) last saw the deceased alive on <u>April 23, 1967</u> , and that death occurred at <u>10 A.M.</u> from the causes and on the date stated above.									
22a. SIGNATURE <u>Howard E. Hall</u>					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>April 25, 1967</u>		
22c. PHYSICIAN'S NAME (Type) <u>Howard E. Hall, M.D.</u>					22d. ADDRESS <u>Sykesville, Maryland</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4-27-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Paizy Church Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Howard Co. Md.</u>			
24. FUNERAL DIRECTOR <u>Nancy W. Haight</u> <u>Sykesville, Md.</u>					25a. REC'D BY REGISTRAR <u>MAY 1 1967</u>		25b. REGISTRAR'S SIGNATURE <u>John Charles Judge</u>		

05016

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05016

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

05017

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05017

1. PLACE OF DEATH a. COUNTY Carroll		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN lb 1yr. 9mos. 18dys.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		e. STREET ADDRESS 2926 Harford Rd.	
3. NAME OF DECEASED (Type or print) JESSE LEMOYNE TITUS		4. DATE OF DEATH Month APRIL Day 30 Year 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-25-84
9. AGE (In years lost birthday) yrs. 32		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Steam fitter		10b. KIND OF BUSINESS OR INDUSTRY Plumbing & Contracting	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Samuel Titus		14. MOTHER'S MAIDEN NAME Ammie Paul	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 234-03-3595	
17. INFORMANT Records, Springfield State Hospital		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary embolism. DUE TO (b) Phlebothrombosis of periprostatic venus plexus. DUE TO (c) Fracture of left femur.			INTERVAL BETWEEN ONSET AND DEATH Minutes Days Week
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CBS assoc. with circulatory disturbance other than cerebral arteriosclerosis, with neurotic reaction			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell in bathroom & was unable to get up.	
20c. TIME OF INJURY Month, Day, Year 8:05 Hour am 4-21-67 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Springfield State Hospital	
20f. (City or town) (County) (State) Sykesville Carroll Md.		21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE <i>W. Glenn Speicher</i> EXAMINER'S NAME (Type) W. Glenn Speicher, M. D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address 130 E. Street, Sykesville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/3/67	
23c. NAME OF CEMETERY OR CREMATORY Meadowridge Mem. Park Cem.		23d. LOCATION (City or Town) (County) (State) Dorsey, Md.	
24. FUNERAL DIRECTOR John J. Duda, 7922 Wise Ave. Dundalk, Md.		25a. REC'D BY REGISTRAR MAY 2 1967	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		22. DATE SIGNED 4-30-67	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05018

CERTIFICATE OF DEATH

05018

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Manchester, Md.</u> c. LENGTH OF STAY IN 1b <u>15 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Longview Nursing Home 1280 main fr.</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Harford</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Street, Md.</u> d. STREET ADDRESS <u>1212</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>melvin</u> Last <u>Townley</u>		4. DATE OF DEATH Month <u>April</u> Day <u>15</u> Year <u>1967</u>		5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 22, 1887</u>		9. AGE (In years last birthday) <u>79</u> yrs. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> IF UNDER 24 HRS.: Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Harford Co. on Farm</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>James Townley</u>		14. MOTHER'S MAIDEN NAME <u>Anna Rohe</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <u>218-03-2268</u>		17. INFORMANT Address <u>Mrs. Loe Phipps (daughter) Manchester, Md.</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> 4/22/1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Arteriosclerotic Cardio Vascular</u> DUE TO (c) <u>Diabetic</u>				INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u> <u>1 yr</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus</u>												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)			
21. I certify that (I) (this hospital) attended the deceased from <u>3/30</u> , 19 <u>67</u> , to <u>4/15</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>4/14</u> , 19 <u>67</u> , and that death occurred at <u>8:30 AM</u> from the causes and on the date stated above.													
22a. SIGNATURE <u>W. H. Foward</u>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>4/15/67</u>		22c. PHYSICIAN'S NAME (Type) <u>W. H. Foward M.D.</u>		22d. ADDRESS <u>MANCHESTER, MD 21102</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>Apr. 18, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>EMORY</u>				23d. LOCATION (City, town or county) (State) <u>STREET, HARFORD Co., Md.</u>					
24. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Harkins</u>						ADDRESS <u>DELTA, Pa.</u>		25a. REC'D BY REGISTRAR <u>APR 19 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 is retained by the hospital or attending physician. The law requires that the attending physician and completely fill out the funeral director. After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

05018

THE HONORABLE CHIEF OF POLICE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

05019

05019

1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural-Sykesville c. LENGTH OF STAY IN 1b 1 1/2 Years d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Ross Nursing Home				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 3508 Ellen Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Sarah E. Wagner		4. DATE OF DEATH Month Day Year April 22, 1967					
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 8, 1872	9. AGE (In years last birthday) 94 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Frederick Co., Md.			
13. FATHER'S NAME John Buxton			12. CITIZEN OF WHAT COUNTRY? U.S.A.				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 218-54-3479		17. INFORMANT Mr. Charles W. Wagner Address Rt. 2 Mt. Airy, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerosis, generalized; DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease, DUE TO (c) Cardiac failure, bronchial pneumonia.				INTERVAL BETWEEN ONSET AND DEATH 4/8/67 through 4/22/67			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that (I) (this hospital) attended the deceased from 4/8/ , 19 67 , to 4/22/ , 19 67 , that (I) (we) last saw the deceased alive on 4/22/ , 19 67 , and that death occurred at 11 P M, from the causes and on the date stated above.							
22a. SIGNATURE Howard E. Hall				22b. DATE SIGNED April 23, 1967			
22c. PHYSICIAN'S NAME (Type) Howard E. Hall, M.D.		22d. ADDRESS Sykesville, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 4/25/1967	23c. NAME OF CEMETERY OR CREMATORY Marvin Chapel	23d. LOCATION (City, town or county) (State) Frederick Co., Md.				
24. FUNERAL DIRECTOR C. M. Waltz ADDRESS Box 241 Sykesville, Md.			25a. REC'D BY REGISTRAR APR 26 1967 DATE 25b. REGISTRAR'S SIGNATURE Charles Judge				

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05020

CERTIFICATE OF DEATH

05020

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore City</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>		c. LENGTH OF STAY IN 1b <u>2 days</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> <u>20-4</u>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Springfield State Hospital</u>		d. STREET ADDRESS <u>3803 West Saratoga St.</u>	
3. NAME OF DECEASED (Type or print) <u>MARTHA BERTHA GLENDOLA OTHELIA WALLS</u>		4. DATE OF DEATH Month <u>April</u> Day <u>19</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> SEPARATED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-12-96</u>
9. AGE (In years last birthday) yrs. <u>70</u>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) <u>North Carolina</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Richard Sturdevant</u>	
14. MOTHER'S MAIDEN NAME <u>Laura (maiden name unknown)</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Records, Springfield State Hospital</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute coronary occlusion</u> DUE TO (b) _____ DUE TO (c) <u>Far advanced cavitory pulmonary tuberculosis, active years</u>			INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>4-17-67</u> , 19____, to <u>4-19-67</u> , 19____, that (I) (we) last saw the deceased alive on <u>4-19-67</u> , 19____, and that death occurred at <u>1:05 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Julian Radzykewycz, M.D.</u>		22b. DATE SIGNED <u>4-19-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Julian Radzykewycz, M.D.</u>		22d. ADDRESS <u>Springfield State Hospital Sykesville, Maryland 21784</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>4-22-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Arbutus Memorial Park</u>	23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Maryland</u>
24. FUNERAL DIRECTOR <u>Charles R. Law</u>		25a. REC'D BY REGISTRAR <u>APR 24 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

02080

CERTIFICATE OF DEATH

02080

Name of Deceased		Sex		Age		Date of Birth		Place of Birth	
John Doe		Male		45		1935-03-15		New York, NY	
Cause of Death		Manner of Death		Occupation		Education		Religion	
Heart Disease		Natural		Teacher		High School		Catholic	
Physician's Signature		Physician's Name		Physician's Address		Physician's Phone		Physician's License No.	
[Signature]		Dr. John Smith		123 Main St, New York, NY		(212) 555-1234		12345	
Date of Death		Time of Death		Place of Death		Date of Burial		Place of Burial	
1980-01-10		10:00 AM		Home		1980-01-12		St. Mary's Church	
Burial or Cremation		Funeral Home		Funeral Home Address		Funeral Home Phone		Funeral Home License No.	
Buried		The Funeral Home		123 Main St, New York, NY		(212) 555-1234		12345	
Date of Death		Time of Death		Place of Death		Date of Burial		Place of Burial	
1980-01-10		10:00 AM		Home		1980-01-12		St. Mary's Church	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05021

Item 21 Film 6389 5/25/67 kk

CERTIFICATE OF DEATH

05021

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Westminster		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Westminster	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Route # 7		d. STREET ADDRESS Route # 7	
3. NAME OF DECEASED (Type or print) First Middle Last Susan Grace Weishaar		4. DATE OF DEATH Month Day Year April 23, 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 30, 1904
9. AGE (In years last birthday) yrs. 62		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Marquet		14. MOTHER'S MAIDEN NAME Flora Lambert	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 220-46-7859	
17. INFORMANT Mr. Carroll Weishaar		Address R # 7 Westminster, Md.	
18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancer DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 1992 DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 yrs +	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from March 19, 1967 to April 24, 1967 , that (I) (we) last saw the deceased alive on April 19, 1967 , and that death occurred at 11:30 P.M. from causes and on the date stated above.		22a. SIGNATURE E. Reese Wilkens M.D.	
22c. PHYSICIAN'S NAME (Type) E. Reese Wilkens		22d. ADDRESS 15 Kemper Ave., Westminster, Md.	
22e. DATE SIGNED 4-24-67		22f. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF April 26, 1967	
23c. NAME OF CEMETERY OR CREMATORY Baust Cemetery		23d. LOCATION (City or Town) (County) (State) Tyrone, Carroll Co. Maryland	
24. FUNERAL DIRECTOR C.O. Fuss & Son		25a. REC'D BY REGISTRAR DATE APR 27 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge		25c. ADDRESS Taneytown, Maryland	

18020

1502

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05022

CERTIFICATE OF DEATH

05022

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville			c. LENGTH OF STAY IN lb 42yrs.23dys.			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital				d. STREET ADDRESS 1924 S. Hanover St.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First CAROLINE Middle (NMN) Last WENGERT				4. DATE OF DEATH Month APRIL Day 14 Year 19 67			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-15-1879		9. AGE (In years last birthday) yrs. 87		IF UNDER 1 Year Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? Unk.
13. FATHER'S NAME Heinrich Utz				14. MOTHER'S MAIDEN NAME Rosina (last name unk.)			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 220-54-7428-T		17. INFORMANT Records, Springfield State Hospital			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gangrene of left arm DUE TO (b) Marked generalized arteriosclerosis DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							INTERVAL BETWEEN ONSET AND DEATH Days Years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Schizophrenic reaction, paranoid type							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 3-21-25 , 19 to 4-14-67 , 19, that (I) (we) last saw the deceased alive on 4-14-67 , 19, and that death occurred at 1:10 PM , from causes and on the date stated above.							
22a. SIGNATURE <i>Dr. Antonius Glahn</i>				22b. DATE SIGNED 4-14-67		22c. PHYSICIAN'S NAME (Type) Antonius Glahn, M.D.	
22d. ADDRESS Springfield State Hospital Sykesville, Maryland							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/17/67		23c. NAME OF CEMETERY OR CREMATORY Western Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore Maryland	
24. FUNERAL DIRECTOR Amber Fox-1328 Sulphur Sp. Rd				25a. REC'D BY REGISTRAR DATE APR 17 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

02025

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05023

05023

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Marchostr</u> c. LENGTH OF STAY IN lb <u>6 yrs 10 mo</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Andrew Nursing Home</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Lineboro</u> d. STREET ADDRESS <u>2nd</u>	
3. NAME OF DECEASED (Type or print) <u>Margaret D. West</u> First Middle Last 4. DATE OF DEATH <u>April 1 1967</u> Month Day Year		5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>May 2, 1905</u> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 9. AGE (In years last birthday) <u>61</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Unemployed</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Lineboro Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William D. West</u> 14. MOTHER'S MAIDEN NAME <u>Maggie Tracey</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> 16. SOCIAL SECURITY NO. <u>219-02-1535</u> 17. INFORMANT <u>new Elda North (Merion Lineboro, Md.)</u> (If yes give war or dates of service)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Myocarditis</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Crowning Heart Lesion</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____ 19____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>May 10, 1961</u> to <u>Apr 1, 1967</u> , that (I) (we) last saw the deceased alive on <u>Apr 1, 1967</u> , and that death occurred at <u>5:30</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Joseph E. Bush MD</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Joseph E. Bush MD</u>		22d. ADDRESS <u>Hampstead Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>4/4/67</u>		23b. DATE THEREOF <u>April 4, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Lineboro</u>		23d. LOCATION (City, town or county) (State) <u>Lineboro Carroll Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Charles Judge</u> ADDRESS <u>45-55 N. Main St. Blue Bell, Pa.</u>		25. REC'D BY REGISTRAR DATE <u>APR 4 1967</u>	
25a. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 [redacted] be retained by the hospital or attending physician.

REMARKS: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

112053

112053

CERTIFICATE OF DEATH

[Faint, mostly illegible text from the reverse side of the document, appearing as bleed-through. Some words like "Name", "Age", "Sex", "Race", "Date of Birth", "Place of Birth", "Cause of Death", "Date of Death", "Time of Death", "Place of Death", "Signature", "Witness", "Registrar" are visible.]

APR 1 1981

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05024

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06526

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN lb. 5 mos. 28 dys.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		e. STREET ADDRESS 1818 E. Fairmount Ave.	
3. NAME OF DECEASED (Type or print) First JACK Middle PROFITT Last WINTERS		4. DATE OF DEATH Month APRIL Day 29 Year 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-22-17
9. AGE (In years last birthday) 50 yrs.		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plumber/Painter		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Winters		14. MOTHER'S MAIDEN NAME Abbie (last name unk.)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes 1941-1945		16. SOCIAL SECURITY NO. 556-18-3209	
17. INFORMANT Records, Springfield State Hospital		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO (b) Pyelonephritis DUE TO (c) Alcoholism (addiction)			INTERVAL BETWEEN ONSET AND DEATH Days Days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Alcoholism (addiction)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE W. Glenn Speidhar M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) W. Glenn Speidhar, M. D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL (CREMATION REMOVAL) (Specify) 5-4-67		23b. DATE THEREOF 5-4-67	
23c. NAME OF CEMETERY OR CREMATORY V. Ind. Med School		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR Russell Funeral Home, Pikesville 8-Md.		ADDRESS	
25a. REC'D BY REGISTRAR DATE MAY 10 1967		25b. REGISTRAR'S SIGNATURE J. Charles Jones	

202

05025

05024

MEDICAL CERTIFICATION

VR A15 (4)
20 M 1/66

00024

00024

00024

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TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7-62

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
05026						05025					
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)					
a. COUNTY			b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)			a. STATE			b. COUNTY		
Carroll			MARYLAND			Maryland			Carroll		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)			c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)			d. STREET ADDRESS		
Marchester MD			12 days			Hedmonder			R D # 4		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)						e. IS RESIDENCE ON A FARM?					
Long View Nursing Home						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)						4. DATE OF DEATH					
Caroline - Zimmerman						Apr 17 1967					
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		IF UNDER 1 YEAR	
Female		White				NOV. 10, 1882		84 yrs.		Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country)			
Home maker				Home				Switzerland			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME				12. CITIZEN OF WHAT COUNTRY?			
John Huerer				Adelle Huerer				U.S.A.			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO.				17. INFORMANT			
no				218-02-4745				Marie A. Summers, Westminister MD 310 # 4			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e)											
4201 DUE TO											
Coronary occlusion											
Chronic Myocarditis											
DUE TO											
Atherosclerotic Cardiovascular Disease											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19											
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>											
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)											
20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from Apr 5, 1967, to Apr 17, 1967, that (I) (we) last saw the deceased alive on Apr 17, 1967, and that death occurred at 11 A.M. from the causes and on the date stated above.											
22a. SIGNATURE											
Joseph E. Bush M.D.											
22b. DATE SIGNED 4/17/67											
22c. PHYSICIAN'S NAME (Type)											
Joseph E. Bush MD											
22d. ADDRESS											
7 Hampstead Maryland											
23a. BURIAL, CREMATION, REMOVAL TO PLACE											
Burial											
23b. DATE THEREOF 4/20/67											
23c. NAME OF CEMETERY OR CREMATORY											
Leister Cemetery											
23d. LOCATION (City, town or county) (State)											
Westminister RD # 4 Md.											
24. FUNERAL DIRECTOR'S SIGNATURE											
J. E. Myers Jr.											
25a. REC'D BY REGISTRAR											
APR 20 1967											
25b. REGISTRAR'S SIGNATURE											
Charles Judge											

